PLANNING FOR A HEALTHIER URBAN ENVIRONMENT IN TOWER HAMLETS

HEALTHY BOROUGH PROGRAMME
HEALTHY SPATIAL PLANNING PROJECT

Detailed Technical Report

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<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Background</td>
</tr>
<tr>
<td>2</td>
<td>Links between health and planning</td>
</tr>
<tr>
<td>3</td>
<td>Re-engagement</td>
</tr>
<tr>
<td>4</td>
<td>Planning impacts on health: evidence</td>
</tr>
<tr>
<td>5</td>
<td>Planning policy</td>
</tr>
<tr>
<td>6</td>
<td>Assessing health in planning</td>
</tr>
<tr>
<td>7</td>
<td>Design and construction</td>
</tr>
<tr>
<td></td>
<td>Good neighbourhood design</td>
</tr>
<tr>
<td></td>
<td>Construction of homes</td>
</tr>
<tr>
<td></td>
<td>Design of homes</td>
</tr>
<tr>
<td></td>
<td>Active design</td>
</tr>
<tr>
<td></td>
<td>Emergency services</td>
</tr>
<tr>
<td></td>
<td>Checklist</td>
</tr>
<tr>
<td>8</td>
<td>Tower Hamlets: health</td>
</tr>
<tr>
<td>9</td>
<td>Planning analysis and interventions</td>
</tr>
<tr>
<td></td>
<td>Interventions</td>
</tr>
<tr>
<td></td>
<td>Recommendations</td>
</tr>
<tr>
<td></td>
<td>Appendix 1</td>
</tr>
</tbody>
</table>
Tower Hamlets was awarded ‘Healthy Town’ status in 2008 and associated Government funding under the Healthy Community Challenge initiative until early 2011 to enable it to tackle health inequalities including obesity. The borough was one of nine Healthy Towns nationally and the only one to be successfully awarded in London. This detailed report along with the accompanying summary paper is derived from the evidence base for the Spatial Planning Project under the Healthy Borough Programme.

Overall, people within Tower Hamlets not only suffer from one of the worse levels of deprivation in the country but also ill-health challenges and a poor quality environment. The latter can have significant influence on health including general wellbeing arising from how and where people live. Research and policy focus on the links between health and planning in the past have included:

- Healthy Cities Programme initiated by the World Health Organisation (WHO) from the mid-1980s onwards
- Healthy Urban Planning by Hugh Barton and Catherine Tsourou published in 2000
- Delivering Healthier Communities in London by the NHS London Healthy Urban Development Unit (HUDU) in 2007
- Good Practice Note on Delivering Healthy Communities by the Royal Town Planning Institutes (RTPI) in 2009
- The Social Determinants of Health and the Role of Local Government by the Local Government and Improvement and Development Agency (IDeA) in 2010, and
- Review of Health Inequalities in England post 2010 by Professor Sir Michael Marmot

Town or spatial planning is the means by which places are managed including the development and use of land. There is clear potential for spatial planning to have significant influence on health including wider determinants (i.e. impact on health arising from where and how people live) contributing towards a built environment which helps to support healthy living and mental wellbeing. This is recognised in the London Plan (2011) the spatial plan for the capital, and the Draft National Planning Policy Framework (2011) which seeks to simplify and consolidate national planning policy. The former treats health as a cross-cutting theme with links to a range of policy areas. The Plan contains strong policy statements on health improvement and reducing health inequalities as well as support for health infrastructure provision. The latter outlines the social role for planning in creating good quality built environments which reflect the community’s needs and aspirations including wellbeing.

This report reviews health and its association with sustainability, the role of local government in advancing the health and wellbeing, evidence on the impact of planning as well as possible interventions to help improve outcomes for the local population.
Public health and town planning have historically been intertwined. In Britain it developed as a reaction to ill-health, urbanisation, rapid population growth and inadequate social infrastructure provision in the nineteenth century. A significant challenge for both was to help achieve better conditions for health and wellbeing for the general population within towns and cities across the country. A large proportion of the population were vulnerable to communicable diseases such as cholera, typhoid, tuberculosis, scarlet fever and smallpox. In terms of scale of their impact, cholera (which arrived in England in the 1830s) killed over 55,000 people by the end of the century, while tuberculosis killed about 80,000 people in 1880 alone. Added to this was extreme poverty, for instance approximately one-third of all Londoners lived in poverty in the 1880s, in places such as Holborn, Stepney, Bethnal Green and Southwark the figure approached half.

Formal identification of the links between unsanitary environments, poverty and ill health were initially made by Edwin Chadwick, in his report ‘The Sanitary Conditions of the Labouring Population of Great Britain’ published in 1842 where he argued for the implementation of better sanitation and drainage. His work led to the establishment of the Royal Commission on the Health of Towns in 1842, Town Improvement Clauses Act of 1847 and subsequent creation of General Boards of Health and publication of the Public Health Act of 1848. Later the Health Act of 1875 consolidated the various Acts and gave local authorities power not only to secure proper standards of drainage and closet accommodation, but also to make byelaws regulating the size of rooms, the space about the houses and the width of the street in front of them.

At the start of the twentieth century, the Housing, Town Planning Etc Act of 1909 identified the role of planning in advancing health. It barred the building of back-to-back housing and allowed local authorities to prepare schemes including development of housing estates. It additionally authorised local councils to ensure that land in the vicinity of towns be developed in “a way as to secure proper sanitary conditions, amenity and convenience in connections with the laying out of the land itself and any neighbouring land”. The Act not only allowed for the regulation of the number of buildings on a site and the space between them, but could also provide both for the control of their appearance, the way that they might be used, and regulated specific types of building use in terms of defined areas.

Parallel to the laws and regulations mentioned above a number of Victorian industrialists and social reformers such as the likes of Robert Owen, Titus Salt, William Hesketh Lever and George Cadbury notably influenced the push for health. Their ‘planned communities’ for their employees included New Lanark in Scotland (early 1800s), Saltaire near Bradford in West Yorkshire (1853), Port Sunlight in Merseyside (1888) and Bournville in Birmingham (1893) engaged in the production of cotton, textiles, soap and chocolate. These developments considered health much more extensively with regards to planning and design than was norm at the time.

The physical planning and design of these planned communities extended from the dwellings and their immediate surroundings (which in some cases included gardens) to area-wide layouts of roads and pathways, community facilities (including churches, schools, clubs and shops), open spaces, parklands to landscaping in a coordinated and spatially mapped framework.
The rationale for these forward thinking industrialists to take such progressive steps was often selfish in nature. Improving conditions related to wellbeing would in the long-term help to reduce days lost to ill health, associated care costs and most importantly contribute to make workers more productive and their enterprises more profitable. Robert Owen (1771-1858) in pursuing improvement in social and working conditions for his workers in New Lanark realised that prevention was better than cure:

"The advanced members of the medical profession know that the health of society is not to be obtained or maintained by medicines; - that it is far better, far more easy and far wiser, to adopt substantive measures to prevent disease of body or mind, than to allow substantive measure to remain continually to generate causes to produce physical and mental disorders".9

William Lever described his building of Port Sunlight as a form of 'profit sharing'.10 He considered that if he were to share the company’s profits with the workers by giving them money they would most likely drink or waste it away. Instead it was preferable to spend such monies on subsided rent and good housing which enabled his workers and families to benefit from the profits made from the company business in a more long lasting way. Such planned communities not only provided a new way of life for a number of ordinary working people with more humane living and working conditions but they also served as notable benchmarks for subsequent thinking related to planning and civic design.

Examples such as Port Sunlight and Bournville contributed towards the subsequent development of the Garden City Movement in the early twentieth century, George Cadbury for example was a founding member along with Ebenezer Howard who was the leading proponent. The latter published a book called the 'Garden Cities for To-morrow' in 1898, where he envisaged towns free of slums, which enjoyed the benefits of urbanised towns including employment and retail for example but also the country including access to fresh air, green space etc (this approach is illustrated in the next page). Thus “by so laying out a Garden City that, as it grows, the free gifts of nature, fresh air, sunlight, breathing room and playing room shall be still retained in all needed abundance.” The Garden City movement contributed towards the development of Letchworth in 1903 and later Welwyn Garden City (see the promotional literature on next page). After the Second World War under the New Towns Act of 1946 such towns numbered well over thirty, these included the likes of Stevenage, Crawley, Milton Keynes, Telford and Redditch etc.

Since the end of the nineteenth century improvements in living conditions along with advances in sanitation, hygiene, nutrition, free school meals for the poor, medicine as well as the establishment of the National Health Service (NHS) have all contributed towards decreasing levels of mortality from communicable diseases. For example, as mentioned there were 80,000 deaths from tuberculosis in 1880, in contrast by 1997 there were only 440. From 1911 to 1915, 63 per cent of all deaths were premature (under 60 years of age) by 1995 however it was 12 per cent. The demise of threats posed by communicable diseases however has gradually begun to be overtaken by a new set of modern threats in particular cancer and circulatory disease (see page 8). In 1997, they accounted for 43 per cent of deaths, in 1880 such diseases made up for less than 10 per cent.12
Garden City Structural approach (right)  

Promotional advertisement for Welwyn Garden City (left)
As communicable diseases began to be better addressed and health conditions improved, so the overarching aims of public health and planning diverged in the post-war era. Public health specialists (as exemplified by the local authority Medical Officers for Health) began to shift away from prevention to that of clinical treatment while planners began to be focused on the ‘control’ of land use development which later developed into inter-related laws and guidance. The 1919 Act for example introduced the concept of interim development control and consent while the 1947 Planning Act for the first time introduced a comprehensive system for the control of development including planning permission. These differing perspectives contributed towards disengagement between the professions and establishment of the succeeding vacuum. Planning concern for the quality of life factors including health which were prominent at the end of the Victorian era increasingly became marginalised after the post-war years.
REFERENCES

1. The Romans for example had a statute which stated that no city should be built until the water supply and sewage systems were in place. Prussia (now part of Germany) in 1719 introduced “collegium sanitatis” to help deal with public health problems and hygiene. This included lighting, ventilation and waste disposal. Later, Johann Peter Frank published in 1766, the first of six volumes on “System einer vollständigen medizinischen Polizei” in which he refers to the prevention of disease being the responsibility of government. (United Nations Report on Planning and Health, 2008)

2. In 1800 the population was about 10.5 million; by 1850 it had increased to nearly 21 million and by 1900 it had nearly doubled again to 37 million. The majority of these people lived in urban areas. By 1851 the country had more urban than rural dwellers, in 1871 there were 14,041,000 urban dwellers and 8,671,000 rural residents (Anthony S. Wohl, Endangered Lives: Public Health in Victorian Britain. London: Dent, 1983)

3. Such diseases were commonly thought from the medieval to the early nineteenth century to be transmitted through ‘bad air’ (miasmatic theory of disease). It was not until the work of John Snow and his study which identified the cholera outbreak of 1854 in London to a public water pump in Broad Street Soho (later revealed to be near an old cesspit) that the focus on ‘bad air’ began to change.

4. House of Commons, 1999, p.9

5. Wohl, 1983, p.44

6. The City of Liverpool pioneered environmental and public health legislation via the 1846 Liverpool Sanitary Act. It gave Liverpool’s Council power to deal with drainage, appoint an officer of health, inspector of nuisance and a surveyor.

7. John Burns introduced the Bill into Parliament by stating that: “The Bill aims in broad outlines at, and hopes to secure, the home healthy, the house beautiful, the town pleasant, the city dignified, and the suburb salubrious” (Professor Sir Peter Hall, TCPA Annual Conference, London, 2009).

8. These planned communities often had social restrictions depending on the views of the industrialist e.g. no pubs or selling of alcohol in the case of Bournville due to the Quaker belief of the founders.

9. R. Owen, Book of the New Moral World (1842), 3rd Part

10. William Lever was later made a Lord due to the success of his Lever Brothers soap manufacturing business now part of Unilever.


13. Ibid. For 1880, the majority of deaths (about 58 per cent) have been grouped as ‘other’ in the diagram. This includes many ‘ill-defined’ (7 per cent) and ‘non-symptomatic’ (9 per cent) deaths as well as deaths of ‘old age’ (5 per cent).

14. Local authority Medical Officers for Health (MOsH) played a key role in tackling environmental health and infectious diseases from the mid-nineteenth century until the 1930s when they began to shift their focus from prevention to that of clinical treatment. MOsH ceased to exist after the 1974 health service reorganisation. (The Medical Officer of Health in England and Wales, 1900-1974: watchdog or lapdog? J. Welshman, Journal of Public Health Medicine, Vol. 19, No. 4, pp. 443-450).

15. Housing acts such as the 1919 Act, which gave the Ministry of Health authority to approve the design of houses, and 1930 Act which required all slum housing to be cleared in designated improvement areas also played a role in advancing health and wellbeing.
Although health was considered in the social housing led re-developments of the 1950s and 1960s, they were done so within the confines of sanitation, room size allocations and health facilities such as local surgeries. From the 1980s onwards when local authorities increasingly ceased to be involved in the delivery of social housing, the explicit mentioning of health seemed to totally disappear as the right-to-buy, owner occupation rates and private developer led initiatives began to take off. It is only within the last decade or so that consideration of health has re-emerged. Research over the last decade or so have re-emphasised the critical links between the built environment and its impact on health this interestingly includes epidemic rates of diseases such as obesity, circulatory disease and mental health.

The push for re-engagement between health and planning has come from the increased recognition that planning can play a critical and positive role in advancing better health for local communities beyond just provision of health care facilities to help treat clinical illness. The medical model of health focuses exclusively on the eradication of disease or illness through diagnosis and effective treatment, the social model (as advanced by the likes of the World Health Organisation (WHO) is a much wider concept, where it is:

“a state of complete physical, social and mental well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental right of every human being, without distinction of race, religion, political beliefs or economic and social conditions.”

Health intervention can occur at three levels. The first of these relate to the behaviour of people so as to improve or limit health damage examples include smoking cessation with regard to lung cancer or exercise and diet in context of obesity. The second is linked to raising awareness and empowering communities at the local level through for instance health partnership initiatives. The third looks at a whole range of social and physical factors that influence peoples’ health and wellbeing. Dalgren and Whitehead (1991) exemplify the latter via their well known diagram, labelled as the ‘wider determinants’ (see below). At the centre are the factors that are relatively fixed i.e. age, sex and hereditary factors, whilst the outer rings are the influencers or conditions that can impact on the health and wellbeing of local communities. The wider or social determinants of health have been defined as:

“the socio-economic conditions that influence the health of individuals, communities and jurisdictions as a whole. These determinants also establish the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs and cope with the environment.”

Barton and Tsourou (2000) suggest that each of the outer rings can be amenable to planning. They continue to place people at the centre but within context of an ecosystem which includes the natural, built environment, activity modes, local economy, community and lifestyle (see next page, second diagram).
Wider determinants of health

Wider determinants and built environment
The social determinants of health not only have links to local human habitat but also critically local government. There are legislative requirements (environmental health, planning, housing, social services, education etc.) as well as additional services such as regeneration and business support which are provided by local authorities that can significantly impact upon the various determinants of health (see below). Such administrations or councils (like their municipal forefathers) can help steer and promote healthy environments within their localities. This includes not only promoting good housing, design or an environment which encourages physical activity (e.g. cycling and walking) but also the commissioners of services and projects.

Numerous local authorities in England within their local Sustainable Community Strategies (the key overarching document for the council or borough) identify the need to provide better conditions for health and wellbeing for their residents. This can be difficult to achieve when the spatial planning principles and structures are not in place to help support this. As a result, helping to support individually orientated action i.e. change behaviour can be difficult to advance.
Like Sisyphus (a King in Greek mythology) who was made to roll a rock up a hill as a punishment by the gods, only for it to roll back down throughout eternity; if health and wellbeing are not considered in the early stages then desired positive outcomes for people within the local community can be difficult or impossible to achieve (see below). Established planning procedure itself in England in many cases does not lend itself to consider health and wellbeing because its focus predominately remains on regulating the development and use of land and buildings rather than place shaping to assist in the delivery of sustainable communities.

The ‘causes of the causes’ of health inequalities

Towards achieving good health outcomes

Equitable access to high quality health and social care services

Empowering individuals and communities

Healthy places

Work and healthy living

Resilience

Reduced health inequalities

Healthy ageing

Unhealthy and unsafe physical environments

Punishment or unhealthy work

Stigma and discrimination

Limited opportunities for education

Poor access to services, transport and good housing

Unhealthy lifestyles

Risk taking behaviour

Injury

Illness

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards

Health hazards
The built environment emerges from human action. The reasons as to why we build can be manifold, however the end results can have significant impacts upon our daily lives. The built environment includes all aspects of the environmental that are modified by humans, including homes, schools, workplaces, parks, industrial areas, and roads. Although more detailed research needs to be done with regard to the built environment and behavioural variables, the urban fabric including how we plan, design and develop places (i.e. place shaping) critically impacts on health. For example, how buildings and places are configured can influence peoples’ living, working and travelling patterns, economic activity, peoples’ opportunities to access services and goods, and their propensity to be physically active.

The form and nature of the physical environment has the potential to impact on social capital and neighbourhood vitality and vibrancy. This perspective is not new, the late Jane Jacobs (who pioneered the modernist approach to urban planning) in her seminar work ‘The Death and Life of Great American Cities’ published in 1961 commented on how complex interaction of multiple variables within cities could affected residents’ quality of life. For urban cities to be healthy Jacobs considered it essential that the physical environment be organised in a way that strengthens social networks of streets and communities. Emphasis needed to be put on good design which deliberated on social context as well as repercussion for residents and visitors. Jacobs considered cities to be living entities which encompassed various ecosystems; over time buildings, streets and neighbourhoods functioned as dynamic organisms, changing in response to how people interacted with them. Her empirical experience and observations often highlighted planning policies that were inconsistent with real-life functioning of city neighbourhoods due to a lack of engagement and contextual understanding.

Whilst knowledge about the links between health and planning is becoming more widespread in practice however these links can be hard to pin down and practical steps to promote consideration often difficult to devise and implement. Most planners have some generalised knowledge about the links between health and planning via for instance Environmental Impact Assessments (EIAs) or Section 106 (a mechanism to help mitigate demands on health from development), their appreciation of the wider determinants are nonetheless often limited due to workload priorities and legislative focus. For public health professionals on the other hand, their interest in the ‘wider determinants’ has helped to re-engage their interest in town planning nonetheless a key practical problem has been their limited understanding of the planning process and linking this to desired health and wellbeing outcomes.

Whilst some planners continue to have doubts and resistance about the consideration of health from a land use point of view, considering it a behavioural issue, the same level of resistance is not found in relation to the concept of sustainable development. Interestingly though, the social definition of health as physical, mental and social wellbeing directly corresponds to the concept of sustainable communities synonymous with spatial planning; this nexus nonetheless continues to be overlooked and not sufficiently explored. The principles of sustainable development are closely aligned and underpinned by health communities (see next page).

The Egan Review commissioned by the then Government in 2004 looked at the agencies responsible for leading delivery of Sustainable Community Strategies across England as well as the skills needed. The Review made no direct reference to sustainability and health but there are significant inter-linkages including synergies between the measures used to mitigate and adapt to climate change and those associated with addressing a number of health issues.
Sustainable communities consequently provide one of the best ways to proactively advance health and wellbeing (prime examples being walkable neighbourhoods, well insulated homes, access to public transport and so on). However this linkage needs to be made more detailed and explicit than is the case currently in context of many local authorities including Tower Hamlets.

The concept of sustainability until recently was predominately based within an ecological perspective which frequently ignored the social dimension of development. This however has gradually changed from the definition as advanced by the United Nations via the Brundtland Commission (1987) i.e. “development that meets the needs of the present without compromising the ability of future generation to meet their own needs” to that of the ‘three pillars’ concept which requires reconciliation of environmental, economic and social demands including that of health. This approach was adopted by the previous Government in its overall policy in advancing sustainable development (see next page). The Planning and Compensation Act of 2004 explicitly made sustainable development a key planning goal however in practice problems remain in terms of the approaches adopted by the various local authorities. In particular greater clarity needs to be embedded in how policy is constructed and projects delivered in an integrated fashion.
In the long term, there are significant co-benefits and synergies to be derived, many of the elements that benefit health also benefit the environment and vice versa. Common examples include provision of green space, reductions in carbon monoxide and nitrogen dioxide from vehicle pollution, provision of sustainable transport, flood prevention measures etc. Although sustainability as a phrase has been around for a couple of decades now it remains a valid and challenging goal for planning not least as it is now no longer pigeonholed as a purely environmental issue.
16. During the 1950s and 1960s town and industrial areas including the East End began to be re-generated after the war. Focus on the need to tackle housing shortages resultant from the delayed sum clearance, unfit homes and increased population growth in cities including London lead to the need to deliver cost-effective rapid build solutions. Modernist architects inspired by Le Corbusier (the famous French architect) set about transforming the urban landscape and creating new communities. It was a top-down process where tenants had little say. Pre-existing neighbourhoods were uprooted and existing urban structures including house and street layouts were demolished. These effects contributed towards the fracturing of social and family links and contributed towards social problems.

18. International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.
25. Wakefield, J (2004), Fighting Obesity through the Built Environment, Environmental, Environmental Health Perspectives, 112 (11), pp.616-618
26. She was a critic of the Garden City concept which according to Jacobs seemed to encourage people to abandon urban cities and their many associated problems in favour of suburban or rural localities as the only means of escape.
27. She was proponent of mixed use developments, cultural amenities, high density developments and walkable neighbourhoods all of which facilitated critical mass enabling neighbourhood vibrancy and vitality.
28. Egan Review Skills for Sustainable Communities (2004), HMSO, Norwich
29. The Johannesburg Declaration on Sustainable Development in 2002 created a collective responsibility to advance and strengthen the interdependent and mutually reinforcing pillars of sustainable development—economic development, social development and environmental protection—at local, national, regional and global levels.
30. Securing the Future - UK Government sustainable development strategy (2005), HMSO, Norwich
How the built environment influences health

4. PLANNING IMPACTS ON HEALTH: EVIDENCE

Increasing amounts of information about health determinants is known about, however there is little on how planning affects those determinants due to a lack of research. In recent years an expanding evidence base has been emerging and a growing appreciation of the links between the built environment and associated health issues. Some observational links are outlined in the diagrams below and next page. The idea that causes of illness and death including heart disease, cancer, cerebrovascular disease and chronic lower respiratory diseases for example may be exacerbated by elements within the built environment is still treated with scepticism by some.
As demonstrated by the complex diagram in the following page, tackling health issues such as obesity is a difficult issue where there are multiple factors at work including biological, psychological, cultural, social etc., within this framework the built environment is not the only component but part of a wider funnel of influence. *The Foresight Report (2007)* on obesity identifies the concept of ‘obesogenic environments’ that promote sedentary behaviour or lifestyle and restrict access or opportunities for physical activity for people. Such an environment can potentially contribute towards people over consuming energy-dense foods (e.g. fast food laden with fat, sugar and salt which is more prevalent due to greater availability, convenience and low cost) and a lack of general exercise leading to imbalance in energy intake and expenditure which can ultimately contribute towards increased body weight and obesity.

As a result of the variable and multifaceted relationship between health and the built environment it has often been difficult to clearly demonstrate a causal relationship and even more difficult to measure the precise contribution of the built environment to disease and ill health. A major contributor to this barrier has been the lack of longitudinal studies as well as cost-benefit analysis of interventions. The upshot has been that it is difficult to precisely define what a healthy development is, and what it is not. There are nonetheless likely to be impacts resulting from the built environment on health, additionally this impact is more likely to be felt by certain groups of the population than others. Those living within cities and on low income can be particularly affected due to their inability to move out of specific locations due to financial considerations. Such factors can be further compounded by issues such as general deprivation and existing poor health factors.

A review of health and planning produced jointly in 2009 by the Kings Fund and NHS Healthy Urban Development Unit (HUDU) entitled ‘The Health Impacts of Spatial Planning Decisions’ suggests that whilst there is the need for further empirical study it did not negate the responsibility of local government or authorities to explore how policies, projects and schemes could potential benefit the health and wellbeing of its residents.
The full obesity system map, which highlights how agents outside conventional mechanistic models can impact the drivers and barriers to change. Variables outside of colored areas relate to social trends and interaction or human biology. Variables are represented by boxes, positive causal relationships are represented by solid arrows and negative relationships by dotted lines. The central engine is highlighted in orange at the center of the map.
The Kings Fund and HUDU report recommends that regardless of the difficulty of collecting evidence it should not stop interventions or actions being adopted that are based on the strong suspicion that they will help deliver beneficial health and wellbeing outcomes. It also identified four key spatial planning issues that were strongly evidence linked to health including housing, public spaces, transportation and flooding (see below).

**Examples of planning issues, health risks and possible mitigation**

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<th>Health risks</th>
<th>Type of health risk</th>
<th>Potential mitigation</th>
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| Housing                    | • Damp and cold homes  
• Excess heat  
• Poor design  
• Isolated developments | • Heart disease  
• Respiratory disease  
• Mental health  
• Injuries  
• Increased mortality and morbidity | • Improving insulation and heating  
• Design that considers mental health |
| Public spaces and services | • Creating sedentary lifestyles  
• Inadequate access to food  
• Inadequate access to health services  
• Unemployment and related issues | • Mental health  
• Circulatory disease  
• Obesity | • Green space to improve mental health  
• Green space to improve rates of physical activity  
• Provision of space to enable exercise |
| Transportation             | • Air pollution  
• Road traffic accidents  
• Noise pollution  
• Creating sedentary lifestyles | • Heart disease  
• Respiratory disease  
• Mental health  
• Obesity  
• Increased mortality and morbidity | • Provision of space to exercise including walking and cycling  
• Reduction in traffic to reduce air pollution  
• Traffic interventions to reduce accidents |
| Flooding                   | • Drowning  
• Injuries  
• Infectious diseases | • Respiratory diseases  
• Shock - cardiac arrest  
• Hypothermia  
• Wound infections  
• Mental health including post-traumatic stress disorder | • Mitigating against flooding |

Like the joint report, the Marmot Report *Fair Society, Healthy Lives* (2010) commissioned by the previous Government to review the state of health inequalities in England identified a number of areas where there were strong links between planning and health, these included housing, air pollution, transport and green space (see next page). By not paying attention to health and health inequalities in the planning process significant unintended and negative consequences can occur according to the report (p.134). The report additionally identified the role of climate change and sustainability considerations within planning as key contributors towards positive health outcomes. Ultimately the report identifies the requirement to prioritise policies and interventions that both reduce health inequalities, help to mitigate climate change and advance sustainability.
### Planning issues identified in the Marmot Report

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| Housing condition and design         | - Improvements in general housing conditions can lead to a number of positive impacts on health including lower rates of mortality especially from ‘winter deaths’ (there were 36,700 in 2008/9 from December to March), improved mental health as well as lower rates of contact with GPs.  
- Better designed homes in terms of materials, ventilation etc, has the potential to lead to 850 fewer adjusted life-years (a method of estimating the negative lifetime impacts of premature mortality and disability) on a yearly basis. It could also provide annual cost saving to the NHS of over £1 billion resulting from falls, injuries and complications.  
- Incorporation of adequate heating systems has the potential to improve asthma symptoms and reduce the numbers of days off school for children.  
- Shortage of homes, many on council waiting lists in temporary accommodation are likely to suffer from overcrowded conditions (for instance children in overcrowded housing are up to 10 times more likely to contact meningitis than children in general), provision of affordable family sized homes has the potential to positively affect overall general health and mental well-being. |
| Outdoor pollution                    | - Outdoor air pollution (mainly from transport and industry) contributes towards cardio-respiratory mortality including 2,000 to 24,000 cases of premature deaths and morbidity per year.  
- Poorer communities experience higher concentrations of pollution and higher prevalence of cardio-respiratory and other diseases. 66 per cent of carcinogenic chemicals emitted into the air are released in the 10 per cent most deprived wards in England (p.80) |
| Transport                            | - Transport not only contributes towards 29 per cent of the UK’s carbon dioxide emissions but also contributes to road traffic accidents and cardio-respiratory mortality, additionally physical inactivity of drivers contributes towards obesity.  
- Children in deprived wards are more likely to be hit by a car: “Children in the 10 per cent most deprived wards in England are four times more likely to be hit by a car than children in the 10 per cent least deprived wards” (p.81). Further, the report identifies black ethnic minority groups in London being 1.3 times more likely to be injured as pedestrians and car occupants on the city’s roads (p.81). |
| Green space                          | - Green space has a significant impact on health and wellbeing. Living close to areas of green space, parks, woodland and other open space can improve health regardless of social background (p.80). Such spaces can assist to decrease health complaints, blood pressure and cholesterol, improve mental health, reduce stress levels and encourage perceived better general health.  
- Indirect benefits of green space identified include greater social contract, increased physical activity/play, improved air quality and reduced urban ‘heat island’ effects. |
| Climate change and sustainability    | - The report highlights climate change, health and health inequalities (p.78). It states that: “Policies concerning sustainable places and communities and designed to mitigate climate change prioritise the environment, and should, and sometimes do, include strategies to improve diet, physical activity, and mental health.” (p.126)  
- Highlights walkable neighbourhoods as generating about 30 per cent less carbon than average for suburban residents due to the need to drive less, this consequently has positive impacts on health in terms of encouraging physical activity (p.78). |
Since the publication of the Marmot Report, additional work was conducted by NICE (National Institute for Health and Clinical Excellence) in exploring spatial planning and its impact on health. This identified a number of areas where links between spatial planning and health inequalities were particularly strong: air pollution, green and open spaces, transport, food, housing and community participation. Other sources of evidence linking spatial planning and health include:

- *Delivering Healthier Communities* (HUDU July 2007) which provides evidence linking five major public health issues - mental health, obesity and cardiovascular disease, respiratory disease, excess summer and winter mortality and injuries – and spatial planning and examples of how planning can help achieve better health outcomes.

- *Sustainable development: The key to tackling health inequalities* (Sustainable Development Commission February 2010) provides detailed evidence of the link between food, transport, green space and the built environment and health equity and sustainable development.

- *Valuing Health: developing a business case for health improvement* (IDEA November 2009) is a literature review that summarises the available evidence and research on the financial and non-financial impact of health improvement activity.

- *Review of evidence for the Mayor’s Health Inequalities Strategy* (GLA October 2009) includes evidence on places – the physical and environmental determinants of health and highlights gaps in the evidence base.
REFERENCES

HUDU presentation (2009)
International, national, regional and local policy and guidance is now increasingly recognising the links between health and urban planning and consequent effects on the built and natural environment as well as wider or social determinants of health.

INTERNATIONAL CONTEXT

*Solid Facts, World Health Organization (2003)* looks at social determinants of health and the role that public policy can play in shaping a social environment that is more conducive to better health. *Healthy Urban Planning, Barton and Tsourou (World Health Organization, 2000)* outlines the core principles of healthy urban planning. This includes

- planners focusing on human health, well-being and quality of life
- making health objectives central to the decision making process
- addressing health as a core element of sustainable development
- improving quality of the built environment in the context of the quality of life of individuals and communities.


NATIONAL POLICY AND GUIDANCE

*Fair Society, Healthy Lives (The Marmot Review, February 2010)* calls for action on six policy objectives to reduce health inequalities, including the creation and development of healthy and sustainable places and communities. It notes that at present, the planning process at local and national levels is not systematically concerned with impact on health and health equity and recommends that the planning, transport, housing, environmental and health systems are fully integrated to address the social determinants of health in each locality. This recommendation reflects the previous considerations of the House of Commons Health Committee, Health Inequalities Third Report of Session 2008-09 (March 2009).

*Department of Health White Paper ‘Healthy lives, healthy people White Paper: Our strategy for public health in England’ (November 2010)* aims to create a ‘wellness’ service (Public Health England) and to strengthen both national and local leadership. Local authorities going forwards will be given responsibility for improving health and for assessing the needs of the local population.
The White Paper set out the Government’s aspiration to “support local areas with streamlined planning policy that aligns social, economic, environmental and health priorities into one place” (p40). Proposals for a public health outcomes framework were published on 20 December 2010. Responding to the challenges set out in the Marmot Review, the framework covers wider determinants of health and health improvement. The White Paper proposes:

- To take forward health considerations in the new National Planning Policy Framework
- To create a new designation to protect green areas of particular importance to local communities
- Increase tree cover
- For active travel and physical activity to become normal community behaviour
- Better designed neighbourhoods and houses that support people’s health and enable active aging to become the norm rather than the exception
- Encouraging development of more homes that are accessible and that meet the needs of an aging population
- Promoting physical activity by children and young people including access to high-quality physical education, encouragement of competitive team sports and supporting walking and cycling

*Healthy Lives Health People Update (July 2011)* outlines the role of Health and wellbeing boards to “provide the vehicle for local government to work in partnership with commissioning groups to develop comprehensive Joint Strategic Needs Assessments and robust joint health and wellbeing strategies, which will in turn set the local framework for commissioning of health care, social care and public health services, and taking into account wider ranging local interventions to support health and wellbeing across the life course (e.g. local planning and leisure policies and working with community safety partnerships and police and crime commissioners)” (para 2.32).\(^{42}\)

The Government has prepared a draft *National Planning Policy Framework (July 2011).*\(^ {43}\) Until this framework is finalised, existing national policy statements will remain in force.

*Planning Policy Statement 1 Delivering Sustainable Development (January 2005)* requires that development plan policies protect human health and address accessibility for all members of the community to a range of facilities including health, leisure and community services.\(^ {44}\) Development plans should also deliver safe, healthy and attractive places to live, and support the promotion of health and wellbeing by making provision for physical activity.

*Planning Policy Guidance Note 17 Planning for Open Spaces, Sport and Recreation (July 2002)* recognises that open spaces, sports and recreational facilities have a vital role to play in promoting healthy living and preventing illness.\(^ {45}\)

*Planning Policy Statement 23 Planning and Pollution Control (November 2004)* states that consideration of the quality of land, air or water and potential health impact arising from a development is capable of being a material planning consideration. Local planning authorities (LPAs) should take account of the risks of and from pollution and land contamination, and how these can be managed or reduced.\(^ {46}\)
There are other references to health in terms of the provision of health facilities (PPS12 Local Spatial Planning, June 2008) in accessible locations (PPG13 Transport, April 2001) and protecting health from waste disposal and management (PPS10 Planning for Sustainable Waste Management, July 2005) and the sitting of telecommunication equipment (PPG8 Telecommunications, August 2001, although health impact is considered outside of the planning process).

The Strategic Environmental Assessment (SEA) Directive 2001/42/EC requires a wide range of public plan or programmes to consider the likely significant effects on the environment, including the effects on population and human health. The Department of Health issued draft guidance on health in strategic environment assessment in March 2007. Current guidance from DH on health in SEA (DH website, dated 4 October 2010) states that if human health is properly covered in SEA a separate HIA is not required. Guidance on health in SEA is currently being revised.

The Environmental Impact Assessment (EIA) Directive (85/337/EEC as amended) requires the assessment of major development projects which are likely to give rise to ‘significant’ environmental effects. Schedule 4 of the EIA Directive sets out the list of information which should be included within an Environmental Statement. EIA should be used to assess the effects (arising during both construction and operation) of development and regeneration schemes on population and human health and propose mitigation measures. EIA is subject to ‘screening’ and ‘scoping’ prior to the submission of a planning application.

The Royal Commission on Environmental Pollution report on the Urban Environment (Twenty-Sixth Report, March 2007) recommends that health issues should be incorporated explicitly in the EIA process. A Health Impact Assessment (HIA) could be used to ensure a more systematic assessment not only of direct health exposures and risks, but also of the impacts on mental health and wellbeing from modern developments (for example, the effect on mental health of anti-social behaviour). HIAs could also check whether a proposal might reinforce health inequalities.

The report recommended that HIA be incorporated explicitly in Sustainability Appraisals, Strategic Environmental Assessments and Environmental Impact Assessments and that there should be a statutory framework for including HIA in the planning process, accompanied by appropriate guidance. The Department of Health (in August 2005) supported the inclusion of HIAs within the EIA process as the best means of considering health issues in the planning process. However, the strategic framework for HIA has not been taken forward.

The Royal Town Planning Institutes’ Good Practice Note 5 Delivering Healthy Communities (June 2009) highlights the crucial role planning has to play in developing sustainable and healthy communities. It includes summaries of the key issues relating to partnership and inclusion, healthy neighbourhoods, planning for active lifestyles, protecting the environment and design for safety and wellbeing. The note recommends that “the impact of proposed developments on human health should be explicitly considered when strategies or schemes are being put forward. This is best done by HIA as part of the wider environmental assessments that are required for schemes or policies.”
THE LONDON PLAN

The Mayor of London’s spatial strategy the London Plan (July 2011) treats health as a cross-cutting theme with links to a range of policy areas including transport, air quality and green infrastructure. The plan contains strong policy statements on health improvement and reducing health inequalities and on the provision health infrastructure to support housing and population growth. Key policies include:

- **Policy 2.4 The 2012 Games and their legacy** - support for ‘convergence’ and opportunity for the Games to help close the deprivation gap and address health inequalities. The legacy Olympic Park development should be designed and built so as to guarantee it’s economic, social, health and environmental sustainability and physical accessibility for generations after 2012 and integrate with regeneration in the wider Lea Valley. The Mayor is preparing an Olympic Legacy Supplementary Planning Guidance which will provide a detailed planning policy framework for the wider area.

- **Policy 2.13 Opportunity Areas and Intensification Areas** – ensures that necessary social and health infrastructure is provided to support and sustain housing growth.

- **Policy 2.14 Areas for regeneration** – support for an integrated approach to regeneration, including health improvement.

- **Policy 3.2 Improving health and addressing health inequalities** – supports the delivery of the Major’s Health Inequalities Strategy and requires new developments to be designed, constructed and managed in ways that improve health and promote healthy lifestyles to help to reduce health inequalities and address the impact on the health and wellbeing of communities.

- **Policy 3.17 Protection and enhancement of social infrastructure** – development proposals should provide high quality social infrastructure.

- **Policy 3.18 Health and social care facilities** - supports the provision of high quality health and social care appropriate for a growing and changing population.

- **Policy 7.1 Building London’s neighbourhoods and communities** – requires that development proposals should enable people to live healthy, active lives and should meet the principles of ‘lifetime neighbourhoods’.

- **Policy 8.2 Planning obligations** – supports developer contributions for health facilities and services.
SUSTAINABLE COMMUNITY STRATEGY AND LOCAL DEVELOPMENT FRAMEWORK

The overarching strategic framework for a borough is the sustainable community strategy. The spatial expression of the sustainable community strategy is carried out through the Local Development Framework (LDF) and in particular the Core Strategy. In Tower Hamlets this was adopted in September 2010, as such it adheres to the previous community strategy, this included a theme of ‘A Healthy Community’ under the aspiration to build ‘One Tower Hamlets’. Going forwards a new community strategy is being drafted, this will include the theme of a ‘Healthy and Supportive Community’. Key policies within the adopted Core Strategy include: 54

- Strategic objective SO3 - the need for plan for healthy environments and the interrelated health benefits of well designed neighbourhoods; high quality housing; access to employment opportunities; access to open space; and shops and services.

- Policy SP03, which supports healthy and active lifestyles. It addresses the impact of noise and air pollution in the borough, provides a hierarchy of accessible, high-quality health facilities, services and premises to meet the needs of the existing and future population. It highlights the need for high-quality leisure centres and social and community facilities and seeks to improve access to the open spaces and sporting facilities of the Olympic and Paralympic Games and their legacy. SP03 also includes the requirement “to reduce the over-concentration of any use type where this detracts from the ability to adopt healthy lifestyles”.

- Strategic Objective SO12 and Strategic Policy 12 recognises the importance of providing a range of high quality green spaces to promote active and healthy lifestyles. Paragraph 6.8 recognises the impact of the quality of the public realm on health and wellbeing.

- Under the ‘Delivering placemaking’ theme Strategic Objective SO25 aims to “create locally distinctive, well designed, healthy and great places which interconnect with, respond and integrate into the wider London area”.

- The Local Area Policy approach seeks to create locally distinctive, well designed, healthy places and includes areas of search for new health facilities, which will link with the PCT’s premises development plan.

Along with the Core Strategy (CS), Tower Hamlets has produced the Development Management DPD Engagement Document (May 2011 for consultation). The DPD forms part of the LDF and sits under the Core Strategy. It proposes policies which seek to create healthy liveable neighbourhoods including policies on healthy and active lifestyles and improving the borough’s air quality. The DPD in general gives more detail to the principles outlined in the CS order to help implement development control.
References

55. http://www.towerhamlets.gov.uk/idoc.ashx?docid=5ecd188c-06c1-4c65-b827-e946920b70c7&version=-1
6. Assessing Health in Planning

The World Health Organisation (WHO) advocates use of Health Impact Assessments (HIAs) as a means of providing decision makers with necessary information about how programmes, policies, projects or proposals will impact (positively or negatively) on health and wellbeing matters. The Gothenburg Consensus Paper on Health Impact Assessment (1999), defines HIA as:

“a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population”.

The use of HIAs can add value to decision making in the development process, its use within England however has been limited because it is not a legal or statutory requirement. At a regional level, while reference was made to HIAs in the old London Plan (2008) under Policy 3A.23 as a requirement for major developments, it was not enforced nor actively pursued by the London boroughs. Where it had been used, it was often been voluntary and confined to long-term regeneration projects or programmes.

The procedure for a HIA commonly involves screening (establishing health relevance), scooping (identification of key health issues), appraisal (assessment of health impacts resulting from the project or proposal) and reporting (providing conclusions or recommendations including mitigations). There are essentially three types of HIA:

- Prospective - prior to implementation
- Concurrent - during implementation
- Retrospective - after implementation

Of most relevance to planning are prospective HIAs, as they can practically influence planning decisions with regards to mitigation or incorporation of elements to support health and wellbeing. Once a development has been given planning consent, it is too late to undertake a meaningful HIA as consent cannot be revoked. There are also issues as to who takes responsibility for the HIA, the developer, local planning authority or the local health trust (including successor organisations)? Additionally, from a planning point of view HIAs are not helped by the general impression that they are rooted in public health and academia spheres, carried out by consultants with limited knowledge of planning and not well framed to development proposals. HIAs also suffer from timescale issues which do not parallel the planning application process. Major planning applications are required to be determined within thirteen weeks however detailed HIAs can require three months or more to carryout depending on the level of complexity.

Overall the general approach to the consideration of HIAs in planning is in stark contrast to Strategic Environmental Assessments (SEAs) and Environmental Impact Assessments (EIAs). Planners working within local planning authorities such as Tower Hamlets have a good level of understanding of EIAs and SEAs given that they are mandatory (see the diagrams on the next page) however this is not the case with HIA because of unfamiliarity and its non-statutory status.
SEA and EIA context

SEAs and EIAs are both meant to enable local planning authorities to consider environmental and social-economic impacts of development before deciding whether or not to grant consent. Major planning applications (0.5 hectares plus or with a significant impact on the environment) are usually legally required to be accompanied by EIAs documented in a final product called an Environmental Statement (ESs) for developments. Although ESs or EIAs consider social and economic impact which could include health, in reality they tend to be restricted to pollution control issues ranging from noise, air quality to contaminated land and often ignore the impact of development including that upon the local community. SEAs form part of the wider sustainability appraisal (SA) process. They assess environmental and social-economic issues related to strategic documents such as plans, programmes and strategies. Assessment of health tends to be based on generalised positive or negative impacts (often again looking at pollution control issues) without any detailed evaluation.
Health Impact Assessment International Best Practice Principles (2006) recognises the link between Health Impact Assessment and Environmental Impact Assessment (EIA), although EIA assessment of health effects is biased towards 'bio-physical health determinants rather than a holistic view that also includes important wider determinants'. It goes on to state that the 'scope of health issues covered may reflect the industrial country roots of EIA, and therefore lack the level of comprehensiveness necessary to make the assessment fully relevant to local health conditions.'

Tower Hamlets (LBTH) have a Scoping Guidance document on EIA which is available for developers (see next page). It recommends an early EIA Scoping exercise whereby applicants consult with planning officers, statutory bodies and other consultees to help inform their request for a Scoping Opinion – this can form part of the pre-application process. It helps to inform and clarify what should be included in the Environmental Statement (ES) as well as provide a guide on required contents and key issues for development within the borough. If scoping is done early and effectively it can save the applicant significant time and resources after the planning application has been submitted. Currently the health requirements in the Scoping document are not very detailed but there are opportunities to strengthen this.

**Overview of assessment in Tower Hamlets**

![Diagram of assessment process in Tower Hamlets](source.png)
HIAs can contribute towards analysis of health and help fill the gaps left by EIAs and SEAs, but it can also add to duplication and creation of increased workload in the planning process. An HIA should not only contribute towards identification of adverse health impacts and mitigation but also recommend positive guidance on design. It is critical that issues and recommendations identified in the HIA are carried through to the planning application submission stage rather than just identified with no subsequent follow-through as sometimes happens. Ben Cave Associates (2009) point out that there are many guides that assist practitioners to conduct HIA, but there is no reference to a particular standard against which the quality of a completed report may be reviewed. The review package provides criteria for assessing the quality of a HIA report submitted with an application for development consent.

For those driven by a growing interest in health, an alternative approach has been to seek to incorporate HIA within an Integrated Impact Assessment (IIA) process to cut costs, resources, duplication and lessen impact assessment fatigue. Integrated Impact Assessment seeks to combine different impact assessments into one process with the aim of assessing sustainability—the balanced integration of economic, social and environmental outcomes. Most commonly integrated Impact Assessments combine an Environmental Impact Assessment (EIA) and a Health Impact Assessment (HIA). The approach avoids the need to undertake and report on separate assessments and seeks to reduce any duplication of assessment work. An IIA was carried out in context of the Mayor of London’s Health Inequalities Strategy (Ben Cave Associates, July 2009) and on the draft London Plan (Entec October 2009).

Although there are various methodological approaches to IIAs, the common end objective nonetheless is to integrate environmental, economic, social and other forms of impact assessment including equalities (which can contain key health related information). The most notable example, the London Plan (2011) utilises an IIA to cover more than one type of assessment in a single process. IIAs can potentially better facilitate an overview of health within a cross-cutting perspective. Criticism levelled at IIAs nonetheless include the perception of health failing to get adequate or no attention as part of the broader assessment process well as the skills of the people doing the assessment.

Whether IIA, HIA or EIA alone is appropriate depends on a number of factors including the ease of implementation, systemisation and usability. For Tower Hamlets where the EIA process is well established and it makes logical sense to use this to help evaluate individual applications. The EIA process covers a number of areas of assessment which consider health implications (as stated these are not cohesive) not least pollution control matters (contamination, air quality, daylight/sunlight etc) and other topic areas including housing, waste etc. Such an approach would require developers to be informed at the EIA scoping stage of requirements. In Tower Hamlets this should be linked in to the Local Development Framework (LDF) Core Strategy key theme of ‘healthy and liveable neighbourhoods’. This theme should also be used in submitted EIAs under which the health profile of the locality of the proposed development and its cumulative impact on residents and communities including wellbeing should be analysed.
Specific locality requirements for EIAs will need to be informed by an HIA conducted at the masterplan or Area Action Plan (AAP) level (see next diagram). This process enables HIA to be independent of individual applications allowing for more time for detailed HIAs to be conducted, reviewed and consulted upon. Cumulatively this along with requirements in the Design and Access statement potentially allows developers to be aware of what is required and positively shape schemes which benefit health and wellbeing before formal applications are submitted.

Regardless of what approach is taken to analyse health, there must be appropriate planning policies and procedures to enable and empower planning officers with regards to negotiations. Development control planners generally are not necessarily reluctant to consider health, however officers are under restrict time constraints, workload pressures and remit with regards to the processing of planning applications. Parallel to this, a level of engagement and knowledge transfer needs to occur at officer and councillor level so that they are aware of the key issues and the rationale behind the need to consider health more widely in planning to deliver long-term liveable and sustainable communities within Tower Hamlets.

Evaluation of health and wellbeing impacts
References

56. European Centre for Health Policy, WHO Regional Office for Europe, Gothenburg Consensus Paper, Health Impact Assessment: main concepts and suggested approach, Brussels: WHO

57. HUDU (2009), Report on use of HIA in London. Policy 3A.23 states that: “Boroughs should require Health Impact Assessments for major development proposals and have regard to the health impacts of development proposals as a mechanism for ensuring that major new developments promote public health within the borough.”

58. Thirteen weeks for major applications and eight for most others.

59. European Directive 85/337/EEC and European Directive 2001/42/EC, the first relates to major projects while the latter deals with plans and policies.

60. www.environment-agency.gov.uk/research/policy/33009.aspx


62. The Council has the power to demand further information if required under Regulation 19 of the EIA regulations irrespective of what is contained in the Scoping Opinion.

63. Tower Hamlets Council Environmental Impact Assessment Scoping Guidance (February 2010), Tower Hamlets Council, p.4. The document sets out issues to be considered under socio-economic impacts, including the impact of the development on community services and facilities and the quality of life, community cohesion, health and amenity. Baseline conditions should be established including information on health needs (paragraph 4.79) and effects should be considered in terms of their overall impact on local communities and the wider area (paragraph 4.80). Direct or indirect impacts which contribute to the ‘quality of life and amenity’, such as noise and air quality should be addressed elsewhere in the Scoping Report under the relevant topics. It may be relevant to cross refer to these technical chapters as appropriate (paragraph 4.81).


65. Development control officers are the planners who process, evaluate and provide officer comments on major planning applications to council development committees or cabinet. Under delegated authority they can also sometimes also make decisions on planning applications themselves.
Design plays an essential role in helping to address or prevent ill-health and promote wellbeing. How places and buildings are designed and created can contribute towards long-term positive outcomes as exemplified by initiatives on slum housing and sanitation linked to infectious diseases in the nineteenth and early twentieth centuries. Similarly with the focus on prevention rather than cure within the modern environment, it is critical that consideration is given to how we plan and design neighbourhoods, homes and places of work or study. Within this paper reference to healthy design relates to places and spaces that correspond to people’s needs. It is important the built environment supports health for example by promoting physical activity including walking and cycling, social capital including mixed use activity, access to services, and mental health via open or green space etc.

Healthy design should ideally encompass a collaborative process between the local community, planning authority, developer and designer; however a common understanding of what is sought often needs to be articulated. To create healthy environments or high quality places a shared perspective and vision is required. Apart from detailed planning policy at borough level, it is also critical to engage with the local community to make sure that designs reflect or consider community needs and concerns at the pre-application stages. Localised perspective and knowledge on building layout, amenity, green space, play space utilisation, walking/cycling routes can all assist to ensure sustainable and well designed neighbourhoods are achieved.

Design and Access Statements are meant to help planning authorities and the local community understand the rationale of a proposed design, how it responds to local context and whether it improves the character, quality and functioning of an area. Currently, such statements contain information related to pedestrian and disabled access, Lifetime Home standards, energy, and sustainability issues etc., these have links to health but are presented in fractured and technical way which detracts from transparency. As a consequence it is hard to know how architects and designers have considered health, wellbeing and liveability as well as whether and how community consultation input has been incorporated. Health and wellbeing design input should ideally be presented within the Design and Access Statement submitted along with the planning application by developers. Again this should be outlined with reference to the Core Strategy and key themes of ‘Strengthening neighbourhood wellbeing’ and the ‘Creating healthy and liveable neighbourhoods’.
7.1 GOOD NEIGHBOURHOOD DESIGN

Strategies for designing neighbourhoods, buildings, streets and outdoor spaces should be based on the principles of improvement and enhancement, how these are considered including relevant framework processes are crucial to help realise implementation. For instance, the old London Plan (2008) required housing sites to provide ‘amenity space’, however it did not specify any requirements for the design of those areas. As a consequence such spaces often appeared unconsidered, without use or function. Additionally, without effective community input and knowledge at pre-design stages issues about appropriateness (e.g. uses and its location) may not be realised or brought to attention. This paper focuses on two areas where considerable positive difference can be made in terms of design, these centre on:

- Firstly neighbourhood design and housing, and
- Secondly ‘active’ design to help encourage physical activity within the built environment setting.

Good housing and neighbourhood design not only provides a basis for a healthy population but also a one which is sustainable in nature. In the past focus was on buildings rather than neighbourhood design, yet the latter connects our homes with the wider borough and city environment. The way in which neighbourhoods are built and the amenities that they provide, the quality of the experience and the attachment that people have to their local areas and the people that live within them are all important to help build social capital and underpin sustainable communities. Social capital is a measure of the residents sense of community and their ability to act together to pursue shared objectives. It is characterised by civic identity and engagement, trust and reciprocity of actions. According some commentators social capital is a contributive determinant of health. Findings from the Place Survey and Annual Residents Survey highlight Tower Hamlets as a place where residents feel less satisfied with their local areas, have less a sense of community cohesion and perceived higher levels of crime.

The general focus within planning tends to be on the development of buildings (residential, office, community facilities healthcare centre etc.), how these fit into the social and functional fabric of communities however is less well considered for a number of reasons. The Commission for Architecture and the Built Environment (CABE) which existed from 1999 to 2011 and subsequently merged with the Design Council, developed an assessment tool called “Building for Life” which looked at a wide range of factors that contribute towards sustainable neighbourhoods. This assessment also provided a framework within which to help support development of social capital as well as health. Although health is referenced within the assessment, it was not highlighted to any significant degree nor was social capital mentioned, nonetheless there exists substantial components within the assessment which can positively contribute towards both.
The elements (see below) range from availability of sustainable transport and community facilities, tenure mix, character of scheme design and layout etc. Building for Life was used as an audit of housing design quality built from 2004 to 2007 by CABE; the findings highlighted the inadequate quality of much of England’s newly built housing. The then Chief Executive of CABE stated that the “evidence shows that the design quality of the majority of new supply is average. If we carry on this way we will leave a sorry legacy to future generations.”

### Building for Life criteria

<table>
<thead>
<tr>
<th>Environment and community</th>
<th>Streets, parking and pedestrianisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>01. Does the development provide (or is it close to) community facilities, such as a school, parks, play areas, shops, pubs or cafes?</td>
<td>11. Does the building layout take priority over the streets and car parking, so that the highways do not dominate?</td>
</tr>
<tr>
<td>02. Is there an accommodation mix that reflects the needs and aspirations of the local community?</td>
<td>12. Is the car parking well integrated and situated so it supports the street scene?</td>
</tr>
<tr>
<td>03. Is there a tenure mix that reflects the needs of the local community?</td>
<td>13. Are the streets pedestrian, cycle and vehicle friendly?</td>
</tr>
<tr>
<td>04. Does the development have easy access to public transport?</td>
<td>14. Does the scheme integrate with existing streets, paths and surrounding development?</td>
</tr>
<tr>
<td>05. Does the development have any features that reduce its environmental impact?</td>
<td>15. Are public spaces and pedestrian routes overlooked and do they feel safe?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Character</th>
<th>Design and construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>06. Is the design specific to the scheme?</td>
<td>16. Is public space well designed and does it have suitable management arrangements in place?</td>
</tr>
<tr>
<td>07. Does the scheme exploit existing buildings, landscape or topography?</td>
<td>17. Do buildings exhibit architectural quality?</td>
</tr>
<tr>
<td>08. Does the scheme feel like a place with a distinctive character?</td>
<td>18. Do internal spaces and layout allow for adaptation, conversion or extension?</td>
</tr>
<tr>
<td>09. Do the buildings and layout make it easy to find your way around?</td>
<td>19. Has the scheme made use of advances in construction or technology that enhance its performance, quality, and attractiveness?</td>
</tr>
<tr>
<td>10. Are streets defined by a well-structured building layout?</td>
<td>20. Do buildings or spaces outperform statutory minima, such as building regulations?</td>
</tr>
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</table>
Each of the criteria above can receive one of three scores, 1 where there is sufficient evidence that the design meets the criteria, 0.5 where a specific part of the design meets the criteria but another does not and 0 where there is not enough evidence or it does not meet the criteria. The overall score is out of 20, a poor rating is one scoring 9.5 or less, average 10 to 13.5, good 14 to 15.5 and very good 16 and above. There may be valid reasons as to why for example a development is not able to achieve desired scores in terms of rating, in such circumstances each development should be assessed on its individual basis. A key criticism of the assessment process for Building for Life however has been related to the subjective nature of evaluation. Objectively there is a lack of alternatives which are as well known or well recognised in the planning and development industry; even with its shortcomings it is a useful mechanism to assist consideration of homes and neighbourhoods as well as a proxy indicator of the quantum of developments that can be considered sustainable and healthy.

7.2 CONSTRUCTION OF HOMES

The design and construction of homes can help support healthy outcomes. Another useful tool is the Government approved Code for Sustainable Homes which evaluates how new homes are built and designed nationally. In April 2007, the Code became standard for the assessment of new housing in England while rating for newly built homes was made mandatory from May 2008. At the end of 2010, the Code was updated and streamlined to avoid conflict with other regulations. Changes included exemption from the Lifetime Homes standard for sites that were too steep in angle, and requirements for waste management plans for sites were also dropped. The Code was aligned to Part L of the 2010 Building Regulations while homes that met Level 4 needed to be 25 per cent more energy efficient than the standards specified in in Part L, a minimum fabric energy efficiency requirement was also imposed.

The Code in its basic form is an environmental assessment method based on the Building Research Establishment (BRE) Ecohomes standard. It enables a rating outcome which is done via assessment against category criteria linked to sustainable design and construction, rating the whole home (Table 1). There are six levels (Table 2) which are made up by achieving both the appropriate mandatory minimum standards together with a proportion of standards that are flexible.

The Code uses a 1 to 6 star rating system (1 being poor to 6 being excellent) to communicate overall performance. Assessment is carried out in two phases. The first phase includes an initial assessment and interim certification at the design stage; this is based on design drawings, specifications and commitments which results in an interim certificate of compliance. The final assessment and certification is carried out after construction, this based on the design stage review and includes confirmation of compliance including site records and visual inspection. Unlike the Building for Life, Code for Sustainable Homes is less subjective and more technical in its approach. A key problem from a health and wellbeing assessment perspective however is that Category 7 (see Table 3) relating to health and wellbeing is optional (a tradable unit) and not mandatory. Developers can pick and choose optional category credits to enable them to achieve rating (see Table 4), consequential it is essential that Category 7 becomes a requirement to help assist consideration of health and wellbeing in the development of new homes in Tower Hamlets. Like Building for Life, the Code for Sustainable Homes can act in a nominal way as a proxy for healthy homes built within the borough.
### Table 1: Environmental categories and weighting

<table>
<thead>
<tr>
<th>Categories of Environmental Impact</th>
<th>Total Credits in each Category</th>
<th>Weighting Factor (% points contribution)</th>
<th>Approximate Weighted Value of each Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 Energy and CO₂ Emissions</td>
<td>31</td>
<td>36.4%</td>
<td>1.17</td>
</tr>
<tr>
<td>Category 2 Water</td>
<td>6</td>
<td>9.0%</td>
<td>1.50</td>
</tr>
<tr>
<td>Category 3 Materials</td>
<td>24</td>
<td>7.2%</td>
<td>0.30</td>
</tr>
<tr>
<td>Category 4 Surface Water Run-off</td>
<td>4</td>
<td>2.2%</td>
<td>0.55</td>
</tr>
<tr>
<td>Category 5 Waste</td>
<td>8</td>
<td>6.4%</td>
<td>0.30</td>
</tr>
<tr>
<td>Category 6 Pollution</td>
<td>4</td>
<td>2.8%</td>
<td>0.70</td>
</tr>
<tr>
<td>Category 7 Health and Well-being</td>
<td>12</td>
<td>14.0%</td>
<td>1.17</td>
</tr>
<tr>
<td>Category 8 Management</td>
<td>9</td>
<td>10.0%</td>
<td>1.11</td>
</tr>
<tr>
<td>Category 9 Ecology</td>
<td>9</td>
<td>12.0%</td>
<td>1.33</td>
</tr>
<tr>
<td>Total</td>
<td>–</td>
<td>100.0%</td>
<td>–</td>
</tr>
</tbody>
</table>

### Table 2: Points and code level

<table>
<thead>
<tr>
<th>Total Percentage Points Score (equal to or greater than)</th>
<th>Code Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 Points</td>
<td>Level 1 (★)</td>
</tr>
<tr>
<td>48 Points</td>
<td>Level 2 (★★)</td>
</tr>
<tr>
<td>57 Points</td>
<td>Level 3 (★★★)</td>
</tr>
<tr>
<td>68 Points</td>
<td>Level 4 (★★★★)</td>
</tr>
<tr>
<td>84 Points</td>
<td>Level 5 (★★★★★)</td>
</tr>
<tr>
<td>90 Points</td>
<td>Level 6 (★★★★★★)</td>
</tr>
</tbody>
</table>
Table 3: Health components and credits for Category 7

<table>
<thead>
<tr>
<th>Issue ID</th>
<th>Description</th>
<th>No. of Credits Available</th>
<th>Mandatory Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hea 1</td>
<td>Daylighting</td>
<td>3</td>
<td>No</td>
</tr>
<tr>
<td>Hea 2</td>
<td>Sound Insulation</td>
<td>4</td>
<td>No</td>
</tr>
<tr>
<td>Hea 3</td>
<td>Private Space</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Hea 4</td>
<td>Lifetime Homes</td>
<td>4</td>
<td>Yes (For level 6)</td>
</tr>
</tbody>
</table>

Table 4: Tradable units

Scoring System for the Code for Sustainable Homes

Categories
- Energy and CO₂ Emissions
- Water
- Materials
- Surface Water Run-off
- Waste
- Health and Wellbeing
- Management
- Ecology

For each category, identify credits awarded as a fraction of the total available

Multiply by weightings factor for each category

Add all the percentage points scores for all the categories

Total percentage points score for level 6

Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Ideally, it would be preferable to have all developers build homes that achieve Code 6 rating with includes being assessed against Category 7 (currently a tradable unit) as well as Lifetime Homes standards which enables homes to be adaptable to the changing needs of their occupants. A key barrier to this however is the costs associated with meeting the higher requirements of the Code. Case study reviews suggest that building to higher environmental standards is more expensive than building homes to building regulations standard. Estimated increase range from around £4000 for a Code Level 3 home to £50,000 for a Code Level 6 home, with building costs excluding land costs and fees, ranging from £900 to £1100 per square meter. Developers however report that they expect building costs to reduce on future projects as systems become more costs effective and supply chain for products become more developed while greater build efficiencies and integration of the sustainability requirements through design is achieved. At minimum Code rating of 5 should be achieved for all new housing in the borough. This should be specified at the AAP level and will need to be in accordance with Planning Policy Statement (PPS) 3 which deals with housing planning policy issued by Government and a robust evidence base. Where sites are not able to meet this requirement developers should explain the circumstantial reasons as to why.

7.3 Design of homes

Code for Sustainable Homes deals with the construction of new homes, however there are issues about how the design and layout of new homes is formulated and delivered. The Royal Institute of British Architects (RIBA) in 2007 produced a report entitled “Better Homes and Neighbourhoods” where it called for the introduction of minimum space standards for all new homes in England and Wales (currently there are no such minimal legal requirements). It observed that new homes sold to people today were significantly smaller than those built in the 1920s, indeed the average floor space of a new dwelling in England and Wales was smaller than most other developed countries (see Figure below).
As land prices have risen, residential developers have sought to maximise profit via getting the most number of units out of their sites. In areas such as London where land prices are high relative to other areas within the country, developers have had to squeeze the maximum number of people into the smallest amount of space. Further, research by CABE via the national housing audit and affordable housing survey found that:

“almost one in three homes (29 per cent) were so poor that they should not have been given planning permission. It uncovered family housing with no play areas, windows looking out on blank walls, and broad expanses of tarmac. Only one in five schemes were rated as ‘good’ or ‘very good’, revealing a disappointing picture of housing quality, and demonstrating that many consumers still get a raw deal when it comes to new homes and neighbourhoods.”

The RIBA policy paper report goes on to suggest that:

“High quality design adds value to homes and their surrounding. It can achieve higher values for development sites, provides greater occupier satisfaction, an improved public realm and prestige for owners. Well-designed sustainable housing will last longer, be more flexible in use, cost less to heat, light and maintain, increase safety and security and grow old gracefully. Good design contributes to a sense of wellbeing – statistics have shown that over £2 billion per year is spent treating illness arising from poor housing stock – more than is spent by local authorities on the building stock itself.”

Central and local government since the 1980s have tended focus on the deliver of the quantum of housing (i.e. housing numbers especially with regards to affordable units) rather than the quality of homes fit for purpose or durability. Newly developed homes in London over the last two decades for instance have reduced in size since the Parker Morris Standard was scrapped as a mandatory requirement in 1980. In many circumstances it has resulted in housing stock which is ill-suited for its occupants, inflexible in meeting changing housing needs and limited legacy potential.

The squeeze on space due to high cost in places such as Tower Hamlets has meant that many studios and one- and two-bed flats have been built as cost implications prohibit larger properties. An added contributor in the past decade has also been investor speculation the buy-to-let phenomenon especially in places such as London as property prices seemed on an ever upward curve and interest rates remained low, many people brought property ‘off-plan’ (often regardless of space consideration, liveability etc) to rent out. This resulted in many developments being speculatively built for buy-to-let investors solely in mind.

Building homes to bare minimal standards has not only resulted in the reduction of storage, circulation space or limited the ability of small children to play indoors due to space constraints but it has also led over the last two decades to the near disappearance of the kitchen as a room within significant proportion of flatted developments. Instead what has emerged are ‘open-plan’ kitchen, dinning and living areas (see diagram on next page). Whilst this may work well in homes with ample living space and well ventilated space in many cases it is ill-suited for people’s purpose. Kitchen areas can occupy for example a corner unit with little storage or food preparation space. Further, it can effectively discourage people to cook and prepare fresh food, eat and relax due to the circulation of smells, steam or condensation transferring into the living area and damaging furniture, carpets etc. It is therefore preferable where possible that kitchen, dinning and living spaces are separated to facilitate functional related activities that do not impede upon each other.
Setting minimum space standards that take into consideration people’s practical requirements and encouraging good design are necessary to help build healthy and sustainable homes that are fit for purpose. Publicly funded homes are improving due to required standards attached to funding (this includes Life Time Homes and Code for Sustainable Homes standards), this is not the case with private sector housing however where homes maybe constructed to lower build standards and be too small for the needs of the occupants they are marketed to.

Critically minimum standards should be applied to all new homes to ensure truly balanced communities. A useful guide is that provided by the Mayor of London entitled the Interim London Housing Design Guide (which is part of the Mayor’s London Housing Strategy). Amongst a number of issues that it looks, it sets minimum space standards related to the internal layout of homes across London (50 square meters for a one bed two person single storey dwelling for instance), minimum combined floor area of living, dining and kitchen spaces, avoidance of single aspect dwellings etc.
All homes developed with funding from the London Development Agency or successor organisation are expected to meet the standards outlined in the Guide from 2011 onwards. The Guide essentially helps to define places and outdoor spaces, density and mixed type development, dwelling space standards and minimum standards for interior and private outdoor usable space, it also looks at climate change mitigation and adaptation. Although intended for public sector the Interim London Design Guide can also be used for best practice or benchmarking for the private sector.

7.4 Active Design

Most people spend a significant proportion of their time within buildings: these may compass a variety of functions ranging from employment, education, business, recreation and entertainment. It has been estimated that 85 per cent of a person’s time in the developed world is spent inside buildings or enclosed space. This can potentially give rise not only to greater obesity and diabetes within the population but also other health related problems. How building and spaces are designed can play a proactive role in assisting to address some of these problems. Critically it can structure layout so as to enable and support physical activity e.g. using specific features of buildings and their immediate surroundings such as stairs and steps to travel between floors or circulation space for informal activity.

Research by National Institute for Health and Clinical Excellence (NICE) found evidence from three studies which suggested that interventions that included changes to the built environment of a worksite may lead to both short and long-term changes in the levels of physical activity. Improving the physical environment of a stairwell by physical improvements such as carpets, painting an addition of art work led to increases in stairwell usage in the short-term. In another study colourful/fluorescent markings painted on a school playground led to assessed increase in variables related to physical activity during playtime.

Currently, there is a great deal of interest in how the physical environment affects physical activity and how changes in the environment can promote active living. The role of the built environment in supporting physical activity varies by the purpose of the activity. Ideally the built environment should integrate physical activity into daily routines. The goal is to help support people to accumulate at least thirty minutes of activity each day. In New York this approach gained acceptance and led to the publication of a guide called ‘Active Design’. At the heart of the Guide is the principle that by providing architects and urban designers with a manual for creating healthier buildings, streets and urban spaces it provides a cost effective solution by integrating physical activity at the earliest stages of development.

The Guide is organised by scale of design intervention with the aid of a checklist, from urban planning or masterplan level down to architectural detail. Elements include land use mix, design of pedestrian pathways, traffic calming, access to grocery shopping, children’s play areas etc. The Guide is not just for architects and designers it has intentionally been made less technical to enable the general public to be engaged in the process and be involved in evaluating building design on behalf of their communities and neighbourhoods. A good example of design intervention to support physical activity is the layout and location of staircases. Rather than having lifts at the front and staircases at the back of buildings hidden from view, it is preferable to have them located at the front to encourage people including those that are able to use them.
The diagram below exemplifies this in terms of design layout consideration, while the diagram in the next page demonstrates how staircases can be attractively and effectively incorporated into an office environment. The guidelines outlined in ‘Active Design’ are voluntary, with architects and planners being encouraged to use the Guide by the City Authority and Mayor.

In a similar fashion to the approach adopted in New York, Sport England has also produced an Active Design Guide to help prompt and enable opportunities for physical activity or exercise in context of new developments. The Sport England guidance is geared towards master planning of new developments and getting people to be active in a number of ways including sport, exercise and recreational activities. It sets out a range of hard (physical) and soft (management) recommendations in promoting everyday activities (e.g. workplaces, shops, schools including active travel routes), informal activity and recreation (e.g. play areas, green space, multi-use games areas) and formal sport and leisure activities (e.g. football pitches, swimming pools, water sports). The Guide is split into three sections which deal with 1) improving accessibility; 2) enhancing amenity; and 3) increasing awareness. Each section contains a series of questions totalling forty six in all. Questions include whether children’s play space is effectively integrated into streets and space to more detailed ones for example about ongoing maintenance.
Both the active design guides mentioned above provide ‘soft’ intervention opportunities that can assist developers, architects, planners and the local planning authority to deliver via design doses of exercise or everyday activity. By promoting awareness, the guides can help prevent consent being given to badly designed schemes or projects which have negative (even if it is passive) consequences on the health and wellbeing of residents, workers and occupants.¹⁷

7.5 Emergency services

Access to buildings and homes is critical for emergency services including ambulances to ensure prompt and efficient response. It is essential that occupants have rapid access to appropriate emergency response. Timely care can improve clinical outcomes for patients with life-threatening conditions such as cardiac arrest. Ambulance response times are based on the following categories: ⁸⁸

- **Category A**: immediately life threatening. An emergency response should reach 75 per cent of calls within eight minutes.
- **Category B**: serious but not immediately life threatening. An ambulance should arrive within 19 minutes 95 per cent of the time.
- **Category C**: not serious or life-threatening. Requirements are set locally.
Category A include people who have collapsed and stop breathing as well as those suffering from immediate heart attacks or strokes. For patients with critical or life-threatening conditions such as stroke, acute cardiac conditions, serious injury and acute breathing problems, a rapid ambulance response and transport to hospital is critical. Consideration should have been given as to how Category A impacts on the layout and design of schemes. There have been instances in newly developed high rise development schemes where paramedics have not been able to use their ambulance trolley beds to remove patients because of lift size. In such cases, a carry sheet may need to be used, which takes more personnel (ideally six), and is a less pleasant experience for the patient while also contributing towards time delays and problems in terms of evacuation. The ability of paramedics to climb stairs with equipment and remain physically fit to treat patients and remove them is likely to diminish with every additional floor in building height that must be climbed.

Ideally, all communal areas and lifts (or a dedicated lift) should be able to accommodate trolley beds. The International Organization for Standardization (ISO) standard for thirteen person lifts has two configurations: 1) square at 1600mm x 1400mm, the other 2) rectangular at 1100mm x 2100mm. Ambulance Trolley beds - 1943x580mm only fit in the latter configuration. The trolley beds have swivel wheels which mean they can move in any direction. They cannot be pushed up or down a slope sideways as they become unstable. The limiting factors is the width of the space in relation to the length of the trolley bed when changing direction, and the need for this a area to be flat. To achieve a 180 degree change of direction, into a parallel corridor or onto a ramp, a space between any walls/length of a flat area needs to be the length of the T/Bed. Many ramps for the use of wheelchair users do not have access points this wide and so cannot be used by the ambulance personnel when a patient requires a trolley bed.

Although this takes more space than the minimum requirements to comply with the Disability and Discrimination Act (DDA), where possible to achieve, it would be desirable. Small changes in levels (arising from changes to surfaces) can pose difficulties for the safe manipulation of trolley beds and the comfort of patients. The London Ambulance Trust have larger vehicles, mostly used for major incidents (equipment vehicles) and specialist responses (CBRN). Although they maybe able to access any designated fire routes, it is useful if ambulances can get reasonable access to all entrances of larger buildings. Consequently, consideration at design and layout stage should be given as to how ambulances will be able to access buildings and internal requirements for rapid access to patients.

7.6 Checklist

Particular consideration in this paper has been paid to toolkits and assessment techniques to help evaluate individual planning applications. Of particular note, is that used by the Homes and Communities Agency (HCA), the national housing regeneration and delivery agency for England. They continue to use English Partnerships’ Quality Standards—Delivering Quality Places (2007), English Partnerships was the predecessor organisation to the HCA. The Checklist provides core common standards, enabling potential partners to plan ahead and adopt policies, products and practices to achieve the quality required. Where possible, they have used existing standards created by other bodies which are understood in the development industry. The English Partnership’s Quality Standard (see next page) looks not only at residential units in isolation, but also includes standards and criteria for the integration of development into the wider area and its long-term management.
### The Delivering Quality Places Checklist 2007

**Design Statements**
- Design statement adhering to the principles of UDC and UDC2

**Building for Life**
- Building for life Silver (or Gold)

**Inclusive design**
- Access statement, taking an inclusive approach to design and adhering to the principles of inclusive design guidance note

**Secured by Design**
- Developments designed by Secured by Design principles and accredited by the local constabulary

**Integration of tenure**
- Tenure-blind development (maximum 6 social units together)

**Car parking**
- Local authority minimum is English partnerships’ maximum. Design in accordance with Manual for Streets and car parking: what works where guide.

### Code for Sustainable Homes and BREEAM
- Code for Sustainable Homes Level 3 minimum for housing (later phases may be higher) and BREEAM very Good for commercial or other building types

**Lifetime Homes**
- All 16 standards for Lifetime Homes must be achieved

**Noise**
- Airborne sound attenuation 5dB higher than Approved Document part E. Impact sound attenuation 5dB lower than Approved Document Part E.

**Building specifications**
- Specifications between A*-C only from BRE Green Guide to Specification and Green guide to Housing Specification

**Overheating**
- Testing required on overheating – for living areas <1 per cent of occupied hours are over an operative temperature of 28C. Bedrooms <1 per cent of occupied hours are over 26C.

**Space standards**
- 1 Bed/2 person homes 51sqm
- 2 Bed/3 person homes 66sqm
- 2 Bed/4 person homes 77sqm
- 3 Bed/5 person homes 93sqm
- 4 Bed/6 person homes 106sqm
- Also requirements for room dimensions and balconies
### Construction Quality

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction efficiency</td>
<td>Construction efficiency statement outlining how developers have used lessons of the Design for manufacture Competition and how new technologies improve the quality and deliverability of the scheme – detail on lending, insurance and consumer warranties.</td>
</tr>
<tr>
<td>Re-use of resources</td>
<td>Land remediation and demolition statements (where relevant) Site waste management plan Re-use of existing buildings and materials where possible</td>
</tr>
<tr>
<td>CEEQUAL</td>
<td>Very Good for construction quality</td>
</tr>
<tr>
<td>Health and safety</td>
<td>Health and safety plan and Construction Design and Management (CDM) co-ordinator appointed</td>
</tr>
</tbody>
</table>

### Rewarding Quality and Delivering Locally

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site-specific issues</td>
<td>Project delivery team to identify site-specific requirements</td>
</tr>
<tr>
<td>Long-term management</td>
<td>Proposals for a long-term management strategy</td>
</tr>
<tr>
<td>Community engagement</td>
<td>Community engagement strategy</td>
</tr>
<tr>
<td>Delivery and financial capacity</td>
<td>Development team, finance and market proposals are deliverable</td>
</tr>
</tbody>
</table>
66. Guidance on changes to the development control system (DCLG circular 01/06) sets out what needs to be included in a design and access statement.


69. The Code has been linked to Part L1A of the Building Regulations, which deals with energy use and carbon performance in new housing. Each level of the Code between 1 and 5 represents an increase in carbon performance compared to 2006 Building Regulations, rising towards the 2016 zero carbon goal for new homes.


71. Ibid. p.16.

72. Ibid. p.17.

73. Ibid. p.192.


75. South Cambridgeshire District Council on their Area Action Plan (AAP) include policy which requires all new housing to be at Level 5. The Planning Inspectorate supported this approach due to their robust LDF evidence base.


78. Parker Morris standard is named after the chairman of the Central Housing Advisory Committee out of which a government report was produced in 1961 called ‘Homes for Today and Tomorrow’. The report recommended minimum space standard for new homes. Developers however usually treated the standard in term of maximum requirement. Parker Morris was mandatory for all council housing but not for private housing.


80. Many of the recommendations are within the Mayor’s Supplementary Housing Guide.


83. The work was commissioned by the New York City Departments of Design and Construction (DDC), Health and Mental Hygiene, Transportation (DOT), and City Planning. http://www.nyc.gov/html/ddc/html/design/active_design.shtml.

84. Ibid. p.81.


89. A high-rise building can be defined as one where the crew have to ascend more than one flight of stairs. Strong consideration must be given to trolley enabled lifts in buildings more than five storeys or above.
There has been significant change in the borough over the last two hundred years leading to patchwork of distinctive places ranging from the likes of Bethnal Green, Whitechapel, Brick Lane, Stepney Green, Bow to Canary Wharf and Wapping. Its position near to the River Thames and the City of London has influenced its social and economic development. In the nineteenth century, the area was well known for its immigrant population, poor housing, crime, ill health and overcrowding. Today the borough continues to have a diverse socio-economic profile with many deprived communities as well as pockets of great affluence. According to the Joint Strategic Needs Assessment (JSNA) report produced in 2009 for the borough it estimates the population at around 235,000. While this is not as significant as in the historical past for various reasons including outward migration (see diagram below) it is due to grow by more than 30 per cent, with over 25,000 new homes forecast to be built by 2020.

Residents within Tower Hamlets suffer from a greater degree of ill-health compared to the rest of the country. The borough has a significantly lower life expectancy than the national average. Males in the borough have a life expectancy of 75.3 years, compared to 77.7 nationally (2005-7), females have a life expectancy of 80.4 years, compared to the national average of 81.8 (2005-7). Mortality is also higher than national average (see diagram on next page: all age morality). The three main causes of death (cardiovascular, cancer and respiratory disease) continue to improve but remain below national average with limited evidence of a reduction in the gap (see diagram relating to early deaths from heart disease and stoke, and early death from cancer).
All age, all cause mortality (right) \(^{93}\)

Early death from heart disease and stroke (left) \(^{94}\)

Early death rates from cancer (right) \(^{95}\)
Four wards (Mile End East, Whitechapel, Bethnal Green North and Shadwell) have mortality rates that are close to twice the national average (see below for a map outline). In males there is a clear polarity in life expectancy between the two most affluent wards (Millwall, and St. Katherine’s and Wapping) where it exceeds 80 years and the remaining fifteen wards where it varies from 71.9 years to 76.5 years. Geographically the ethnicity of Tower Hamlets is also not uniformed. The North East of the borough around Bow has high levels of White ethnicity, whilst the large Bangladeshi population is concentrated more toward the east of the borough in Shadwell and Whitechapel as well as in a corridor along the Whitechapel road running east to west across the borough. The ethnicity of a population has links to many health outcomes, such as hypertension and diabetes, when combined with the different age structures seen in these populations this can contribute to some of the large disparities in health outcomes seen across the borough.

According to the JSNA there is a stronger (although weak) correlation between higher life expectancy and a higher proportion of Bangladeshi women in the ward population. Hypothetically the JSNA suggests that this could be linked to lower smoking rates and alcohol use compared to white females. 97
There seems to be a strong link between ward deprivation and mortality within Tower Hamlets which ranks as the third most deprived local authority in England according to the Indices of Deprivation (2007). Virtually the whole of the borough is deprived (see below) however there are significant variations between wards as exemplified in the diagram in the next page. Tower Hamlets has the highest proportion of its children and older people in income deprivation of any local authority in England. Deprivation itself is not a measure of health, but rather it serves as an indicator of behavioural and physical factors that are associated with poor health outcomes. For example a poor diet lacking in fruit and vegetables and high in saturated fats from cheap processed foods or physical inactivity can increase the risks of heart disease, stroke, high blood pressure, diabetes and some cancers. In females, the link with ward deprivation is less clear cut.
Mortality only gives a partial picture of the burden of disease in the Tower Hamlets, this is because some conditions may not lead to death but nevertheless have a significant impact on quality of life e.g. asthma, musculoskeletal disease, depression etc. Estimating how many people in the population have a particular disease is not straightforward. Health service data has limitations because not everyone with a condition will access services. The prevalence of common chronic health conditions also varies across the borough; three areas nonetheless stand out these include LAPs 4, 6 and 7 (see the table on the next page). Within LAP 4 prominent conditions include those of a vascular nature such as hypertension, diabetes, ischemic heart disease as well as depression and COPD. LAP 6 has problems linked to vascular conditions also but interestingly scores highest in the borough for dementia. LAP 7, scores the most for asthma (this is not helped by having major roads which are heavily congested), epilepsy and depression as well as the second highest score with regards to dementia.
From a further review of the health profiles of the LAP areas, they can be clustered in terms of:

- LAPs 1 and 5 – similar to borough averages.
- LAPs 2 and 3 – lower prevalence rates than borough averages.
- LAPs 4, 5, 6 and 7 – generally significantly higher prevalence rates.
- LAP 8 – lower prevalence consistent with affluence and ethnic composition.

Geographically there are considerable differences between the wards or LAP areas and corresponding life expectancy. The major causes of death in Tower Hamlets are to various degrees all affected by both lifestyle behaviours as well as environmental factors. Cardiovascular diseases for instance are linked not only to a poor diet, but also physical activity, excessive environmental noise, and air pollution. The latter can contribute towards respiratory disease and increased risks for children with asthma and people with COPD while carcinogenic particulate matter from road traffic is associated with increased cancer risk.

<table>
<thead>
<tr>
<th>LAP</th>
<th>Asthma</th>
<th>Hypertension</th>
<th>Depression</th>
<th>Diabetes</th>
<th>IHD</th>
<th>CKD</th>
<th>COPD</th>
<th>Stroke</th>
<th>MI</th>
<th>Epilepsy</th>
<th>Dementia</th>
<th>Overall</th>
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<tbody>
<tr>
<td>1</td>
<td>5 (9.3%)</td>
<td>5 (7.5%)</td>
<td>5 (8.0%)</td>
<td>6 (3.9%)</td>
<td>5 (1.9%)</td>
<td>5 (1.1%)</td>
<td>5 (1.4%)</td>
<td>4 (0.9%)</td>
<td>5 (0.7%)</td>
<td>4 (0.4%)</td>
<td>8 (0.1%)</td>
<td>35.2</td>
</tr>
<tr>
<td>2</td>
<td>7 (5.2%)</td>
<td>8 (4.6%)</td>
<td>7 (5.0%)</td>
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<td>7 (1.2%)</td>
<td>8 (0.2%)</td>
<td>8 (0.5%)</td>
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<td>21.3</td>
</tr>
<tr>
<td>3</td>
<td>8 (4.6%)</td>
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<td>22.6</td>
</tr>
<tr>
<td>4</td>
<td>2 (12.3%)</td>
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<td>4 (9.5%)</td>
<td>4 (9.1%)</td>
<td>4 (4.2%)</td>
<td>2 (2.1%)</td>
<td>4 (1.8%)</td>
<td>4 (1.5%)</td>
<td>2 (0.9%)</td>
<td>4 (0.8%)</td>
<td>2 (0.5%)</td>
<td>4 (0.2%)</td>
<td>40.2</td>
</tr>
<tr>
<td>6</td>
<td>3 (11.4%)</td>
<td>2 (13.2%)</td>
<td>3 (9.2%)</td>
<td>5 (7.6%)</td>
<td>3 (1.1%)</td>
<td>1 (2.6%)</td>
<td>3 (1.7%)</td>
<td>5 (1.5%)</td>
<td>1 (1.3%)</td>
<td>2 (0.5%)</td>
<td>1 (0.4%)</td>
<td>52.4</td>
</tr>
<tr>
<td>7</td>
<td>1 (12.4%)</td>
<td>3 (10.2%)</td>
<td>2 (9.9%)</td>
<td>3 (5.3%)</td>
<td>1 (2.1%)</td>
<td>2 (1.9%)</td>
<td>2 (1.9%)</td>
<td>1 (1.2%)</td>
<td>3 (1.0%)</td>
<td>5 (0.7%)</td>
<td>1 (0.3%)</td>
<td>47.3</td>
</tr>
<tr>
<td>8</td>
<td>6 (6.4%)</td>
<td>7 (4.7%)</td>
<td>6 (5.3%)</td>
<td>8 (2.1%)</td>
<td>8 (1.2%)</td>
<td>7 (0.6%)</td>
<td>6 (0.7%)</td>
<td>3 (1.9%)</td>
<td>7 (0.4%)</td>
<td>8 (0.4%)</td>
<td>6 (0.3%)</td>
<td>22.2</td>
</tr>
</tbody>
</table>

Borough Average: 8.4%
A number of long-term conditions can potentially be amenable to change (improving the quality of life) through the built environment. It makes sense to ensure that planning pays attentions to areas which suffer from health problems and to ensure that the physical environment helps to support better outcomes. The majority of the LAPs are likely to be amenable to planning opportunities for health and wellbeing gain due to the quantum of development anticipated up to 2020. The most significant area for intervention is LAP 8 which is expected to increase its population by 31 per cent; the area with the smallest opportunity is LAP 4 which is expected to experience a population increase of only 6 per cent. Unfortunately LAP 4 is also an area with high levels of illness and pressing health needs within the borough. The contrast between LAP 4 and 8 nonetheless should not mean that planning intervention be weighted against the former and towards the latter, health and wellbeing improvements should be maximised within each LAP area where it presents itself however small it may be. Such change over time within a cumulative context can help delivery considerable positive change for the borough as a whole.
References

90. Tower Hamlets Local Development Framework Core Strategy (2010)
91. Office for National Statistics Census Data
93. Association of Public Health Observatories (2008), Health Profile for Tower Hamlets, p.3
94. Ibid
95. Ibid
96. Tower Hamlets Local Development Framework Core Strategy (2010)
99. Association of Public Health Observatories (2008), Health Profile of Tower Hamlets
100. Tower Hamlets, Joint Strategic Needs Assessment (2009)
While there is a rich array of buildings and structures that hold great architectural, historical and modernist value in Tower Hamlets there are also areas which are poor in character and environment. Such areas in turn can influence quality of life issues for residents and the local community. Within this framework the development of new buildings and places can potentially have significant impacts on wellbeing within Tower Hamlets, however little is known about how health for instance is considered within the planning application process. With the above in mind, a sample analysis of ten approved application was undertaken as part of this study (see Appendix 1). The assessment looked at applications that were residential in nature and had been approved by the Strategic Development Committee (the authorised Council body at the time which considered planning applications). The review drew on available information online from committee reports and the applications register over an eighteen month period starting in March 2008. Not all of the required information were available online due to the size of files, nonetheless an indicative level of information overall was obtained. The review essentially considered the extent to which key reports underpinning the planning application process (i.e. planning statements, design and access statements, environment impact assessments etc) considered health; it did not evaluate the contextual nature of the health impacts or financial viability of the schemes involved.

The review (see table on next page) found certain elements of health were taken into account however they were not cohesive in facilitating a health overview. For instance EIAs analysed pollution control elements such as air quality, noise and daylight assessment but they were done so within an isolated and fractured context with no links to social or community health interconnections. It was also common for health infrastructure to be mentioned but only in relation Section 106 and in particular only with reference to GP surgery capacity while other health service impacts (including A&E and mental health) were not evaluated.

Although there were plenty of references to good design in reports, the impact of design on health was not apparent. Design and access statements for instance considered nearby buildings, massing, building layout, Code for Sustainable Homes, Life Time Home standard, walking or cycle provision but did not evaluate overall health outcomes. Interestingly no HIAs were done for any of the developments analysed nor the health of the local community within which development were proposed considered. Rather than contributing (in a visible way) towards health and wellbeing the development process and procedure made it opaque. Thus to determine whether a development was making a positive or negative contribution (including what level) towards health and wellbeing for residents and the local community was not apparent.

With the delivery process there also appeared to be issues surrounding consent being given to a development and what was actually delivered on the ground which turned out to be inferior to what was described and mentioned in the planning application. In order to help secure and importantly deliver good quality developments in Tower Hamlets which is beneficial for health and wellbeing in the long term, it is critical that the planning authority not leave decisions on materials and the landscape to be dealt with by the way of planning conditions (design is often cumbersomely re-negotiated through the discharge of conditions). The planning application stage should be used effectively to help ‘tie down’ the design and requiring larger scale drawings which clearly demonstrate a sufficient level of detail which prevents developers from diluting design quality once planning consent is granted.
Research findings

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Infrastructure</td>
<td>Yes (all)</td>
<td>8 out of 10</td>
<td>Yes (all)</td>
<td>None</td>
</tr>
<tr>
<td>Consideration of health profile of the local community</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Wider determinants of Health (role of design on health, green space and mental health etc)</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Housing and links to health</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Monitoring or assessment of development on health of residents</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

A more proactive (rather than a reactive) approach to design lies in the preparation of urban design briefs, masterplans and AAPs that consider health and wellbeing more explicitly, additionally there is also the need to ensure that there is sufficient design expertise and capacity to not only ensure delivery of high quality design but also help promote innovative approaches and solutions to the regeneration of the urban environment in Tower Hamlets. Another key problem for health is that of post-consent monitoring.

Town planning normatively can be broken down into three stages, 1) place shaping which involves agreeing a vision and outlining planning policy, 2) place making the process of translating the policy or development objectives into design and delivery, and 3) the monitoring of impacts. Presently there is a lack of good quality information being feedback on developments post-occupation. Without feedback how are we to know which developments have worked well and those not so? How schemes have worked in terms of their integration into the local community and economy? What have been the key problems or successes? This requires not only assessment by planners but also the gathering information including sample interviews from residents, occupants and users of schemes given consent.

As reviewed, the health problems of today are different from those identified in the eighteenth century however the need to provide a built environment which takes health into consideration remains as important as ever. In helping to advance this planning can be a key enabler of change to help deliver the opportunities for people to lead physically, psychologically and socially satisfying lives in Tower Hamlets. The findings from this report suggest that there are opportunities for health and wellbeing to be considered in a more holistic fashion than currently is the case however this has to be done in a considered and practical way.
9.1 Interventions

While there exists significant information and guidance on planning and health, a continued practical problem has been the need for practical tools or instruments to ensure that desired policy objectives can be translated into healthy developments on the ground (this is what this piece of work tries to address as an initial step). Some important work has already been started which is to establish health as a planning consideration in the LDF Core Strategy. Further downstream work needs to be done to ensure that policy objectives relating to health are delivered on the ground through more detailed policy guidance especially the LDF Development Plan Documents (DPD).

The review of major residential developments in Tower Hamlets found that certain elements of health were taken into account however they were not cohesive in facilitating a health overview. Practical steps are needed to ensure that health and wellbeing are appropriately assessed when planning applications are submitted. In approaching possible tools to help facilitate delivery of planning intervention this report looks at a mixed approach using existing sustainability tools, design guidance and assessments. These are structured around key themes identified in the Kings Fund and HUDU joint report as well as the Marmot report and follow-on from the Homes and Communities Agency adopted Quality Standards checklist. These are separated into two categories i.e. housing and external impacts (see tables). They include areas such as housing design, outdoor pollution and transport, green and active space, and lastly sustainability and climate change.

Spatial planning decisions have profound impacts on the health and wellbeing of communities. If these impacts are to be optimised for Tower Hamlets, the scope for delivering positive long-term health and wellbeing outcomes must be recognised and specific policies adopted to achieve this. The recommendations outlined in the following pages will assist or help realise the objectives outlined in the diagram below.

![Diagram showing the cycle of achieving outcomes: Sustainable communities → Planning which considers health and wellbeing → Evaluating and monitoring outcomes → Better built environment → Enhanced liveability of homes and places → Increased social and environmental capital → Sustainable communities]
Planners are under considerable pressure to deal with planning growth, associated workload, political as well as governmental considerations including budget constraints and pressures to process applications within appropriate timetables. Within this framework, planning can often be seen to be driven by rules and processes. There are also significant challenges in not over burdening developers with regards to demands, examples include multiple assessment studies and expenditure of unnecessary resources that are not relevant to mitigating the negatives impacts of proposed developments. All these factors generate competing and conflicting interests, whereby health, wellbeing and liveability can be overlooked without being realised. It is essential therefore that these elements are mainstreamed into the planning process as far as possible to help inform developers of requirements and enable planning officers to consider health and wellbeing more robust.

<table>
<thead>
<tr>
<th>Potential tools for addressing health issues identified</th>
<th>Health issues potentially addressed</th>
</tr>
</thead>
</table>
| **1) Code for sustainable Homes (4 and above).** This incorporates:  
  - Sustainable design and construction of units  
  - A high degree of insulation and energy efficiency  
  - Homes that are accessible and adaptable to people’s changing circumstances (optional up to level 5)  
  - Considers daylight, sound insulation and flood risk |  
  • Respiratory disease – preventing cold/damp homes  
  • Mental health – ensuring daylight, sound insulation and overcrowding is prevented |
| **2) Building for Life (14 and above), assess how well homes and neighbourhoods are designed, these include:**  
  - Access to community facilities  
  - Building design and layout  
  - Social/tenure mix  
  - Access to public transport/vertical curving provision  
  - Environmental sustainability/impact |  
  • Cardiovascular/obesity – better design to enable walking and cycling  
  • Mental health – by providing social tenure mix for balanced communities, and positive environmental conditions |
| **3) London Housing Design Guide, provides advice on:**  
  - Shared circulation, lift provision  
  - Car parking, cycle storage, refuse  
  - Minimum internal floor space (50 sqm for a 1 bed flat)  
  - Circulation in the home  
  - Dinning/kitchen area (23 sqm for a 1 bed flat)  
  - Bedroom size (8.4 sqm for a single bed flat)  
  - Provision of wheelchair accessible entrance level WC with drainage enabling a shower to be fitted in the future  
  - Bathrooms designed to incorporate ease of access to bath, WC and wash basin  
  - WCs capable of taking adaptations |  
  • Mental health – by providing sufficient space for privacy, mobility in terms of physical access and use of facilities  
  • Obesity – by providing a sufficient space in the kitchen area to prepare and store food |
| **4) Secure by Design, reviews planning application in light of:**  
  - Improve safety by considering design related crime and safety (helping mental health and wellbeing). |  
  • Mental health – by addressing the fear of crime  
  • Cardiovascular/obesity – by enabling people to walk/cycle outside |
| **5) Provision of affordable homes, via targets and design guidance help to ensure:**  
  - Residential stability and prevention of crowding |  
  • Mental health – by addressing overcrowding |
<table>
<thead>
<tr>
<th>Potential tools for addressing health issues identified</th>
<th>Health issues potentially addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6) Air quality assessment:</strong></td>
<td>• Respiratory disease – by limiting or helping to reduce air pollution</td>
</tr>
<tr>
<td>• Assessment of major developments and potential impacts including additional pollution from road traffic and demand on natural resources</td>
<td></td>
</tr>
<tr>
<td><strong>7) Sustainable travel/transport:</strong></td>
<td>• Cardiovascular/obesity – through facilitating cycling and walking</td>
</tr>
<tr>
<td>• Car free developments</td>
<td></td>
</tr>
<tr>
<td>• Green travel plans</td>
<td></td>
</tr>
<tr>
<td>• Cycling/walking routes</td>
<td></td>
</tr>
<tr>
<td>• Public transport</td>
<td></td>
</tr>
<tr>
<td><strong>8) Protection of existing open, green space and parks:</strong></td>
<td>• Cardiovascular/obesity – to enable walking, cycling, and play activities</td>
</tr>
<tr>
<td>• Using planning policy outlined in the national planning policy (PPS9 and PPS17) as well as regional planning policy guidance including London Plan (2008) on Metropolitan open land, Blue Ribbon Network, children and young people’s plan and amenity space.</td>
<td></td>
</tr>
<tr>
<td><strong>9) Creation of new green spaces:</strong></td>
<td>• Mental health – by providing green space</td>
</tr>
<tr>
<td>• Development and implementation of the Green Grid project as outlined in the LDF Core Strategy to help promote active and healthy lifestyles.</td>
<td>• Cardiovascular/obesity – to enable walking, cycling, and play activities.</td>
</tr>
<tr>
<td><strong>10) Promoting opportunities for sport and physical activity:</strong></td>
<td>• Cardiovascular/obesity – to enable physical activity</td>
</tr>
<tr>
<td>• Use Sport England guidance on active design to promote active recreation</td>
<td></td>
</tr>
<tr>
<td><strong>11) Sustainable development:</strong></td>
<td>• Respiratory disease - by limiting or reducing air pollution</td>
</tr>
<tr>
<td>• As outlined in PPS1 and Policy 2A.1 of the London Plan, there is a need to consider sustainability as part of any development</td>
<td></td>
</tr>
<tr>
<td>• Renewable energy (including 20% onsite as set out in the London Plan)</td>
<td></td>
</tr>
<tr>
<td>• Zero carbon developments</td>
<td></td>
</tr>
<tr>
<td>• Code for Sustainable Homes (see above)</td>
<td></td>
</tr>
<tr>
<td>• Sustainable travel/transport (see above)</td>
<td></td>
</tr>
<tr>
<td><strong>12) Flooding prevention measures:</strong></td>
<td>• Mental health – by mitigating against flooding</td>
</tr>
<tr>
<td>• Drainage systems</td>
<td></td>
</tr>
<tr>
<td>• Appropriate run-off areas</td>
<td></td>
</tr>
<tr>
<td>• Green space, green/brown roofs</td>
<td></td>
</tr>
</tbody>
</table>

**Outdoor pollution & transport**

**Green and active space**

**Sustainability and climate change**
9.2 Recommendations

The recommendations outlined from this report as a result of the review process are structured around: 1) assessments to help evaluate development schemes; 2) ensuring homes are sustainable and healthy; 3) design support for health and wellbeing; 4) involving residents; and 5) influencing development at an early stage.

1. Assessments to help evaluate developments

- Health Impact Assessment (HIA) to be carried out on AAPs, master plans and large scale regeneration developments.

- Use of Building for Life (BfL) assessment for sustainable neighbourhoods at the application and post-occupation stages to gauge how well developments have integrated and delivered positive outcomes.

- BfL assessments should be carried out for all major residential applications (150 plus units) with a minimal rating of Level 14 (good) or above at the planning application stages.

2. Ensuring sustainable homes are healthy

- All new homes should be assessed against the health and wellbeing criteria set out in the Code for Sustainable Homes (CfSH), the national standard to guide industry in the design and construction of sustainable homes.

- All developments to meet at least Level 5 of Code for Sustainable Homes to ensure homes are healthy.

- Lifetime Homes Standard (mandatory at Code Level 6) should be considered by developers to ensure that homes are adaptable in meeting the needs of occupants at different stages of their life.

3. Design support for health and wellbeing

- A proactive approach to design should promote the health and wellbeing of new residents.

- Design and Access Statements should outline how health and wellbeing have been considered.

- Ensure sufficient design expertise and capacity to help with the delivery of a high quality environment and restrict opportunities for developers to dilute design quality when individual planning consents are granted.

- Use of the Mayor of London’s Interim Housing Design Guide and Housing Supplementary Planning.
• Guidance to ensure provision of good quality and liveable homes for all.

• To facilitate flexibility, developers and registered social landlords should be encouraged to adopt modular housing design to facilitate future changes in housing needs within the borough.

• Drawings submitted for developments at the application stage should reflect real size furniture by having standard size tables, chairs, sofas and beds. This will help visually inform purchasers of new homes as to room size, layout and circulation space.

• There should be reasonable storage space for occupants including household appliances, clothes and personal belongings. There should also be sufficient space for food storage and preparation while separate kitchen and living space should be the norm. Where open plan kitchen and living space layouts are proposed these should be justified.

• The concept of ‘active’ design should be pursued by designers and developers including for example designing welcoming stairwells, informal play areas, walking and cycling routes to enable people to be physical active in their daily lives.

• Access ramps and lifts should be able to accommodate use of an ambulance trolley beds where practicable, for example ISO standard 13 person lifts should always be provided in the rectangular configuration as this can accommodate a trolley bed as apposed to the square configuration which cannot.

4. Involving residents

• Along with review of BfL assessment at post-occupation stages, qualitative information via sample interviews should be gathered from residents on how well developments have contribution towards sustainability and liveability within their localities.

5. Influencing development at an early stage

• Pre-application discussions and consideration of health impacts should take place with developers before scheme initiation where possible and the use of assessments including BfL and CfSH should be monitored to ensure that they are effective in delivering desired outcomes.

• Currently developers are not accountable for the long-term impacts of their development on their occupants. There should be a long-term study of health impacts arising from the construction and occupation of individual developments, which could be funded by developers via Section 106, a key issue remains however as to who would be responsible for adverse impacts post-build and occupation.
<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/09/0662</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: socio-economic, transport, energy, landscape, air quality, noise, sunlight/daylight and contaminated land (the last three reviewed by Environmental Health).</td>
</tr>
<tr>
<td></td>
<td>- Reviews: housing amenity space and communal/child play space.</td>
</tr>
<tr>
<td></td>
<td>Puts conditions on the following:</td>
</tr>
<tr>
<td></td>
<td>- Remediation measures for land contamination</td>
</tr>
<tr>
<td></td>
<td>- Environmental management plan</td>
</tr>
<tr>
<td></td>
<td>- Sustainable design measures</td>
</tr>
<tr>
<td></td>
<td>- Limiting hours of construction</td>
</tr>
<tr>
<td></td>
<td>- Need for all residential accommodation are to be built to Lifetime standards</td>
</tr>
<tr>
<td></td>
<td>- Green Travel Plan</td>
</tr>
<tr>
<td></td>
<td>- Residential design level 4 Code for Sustainable Homes Criteria</td>
</tr>
<tr>
<td>Location of Development</td>
<td>Planning Statement</td>
</tr>
<tr>
<td>100 Violet Road, London, E3 3QH</td>
<td>- Mainly design options related, mentions refuse collection issues, Life Time Homes and Wheelchair Access standards. It does not look at health directly nor analyse existing population or neighborhood context</td>
</tr>
<tr>
<td>Number of new housing units</td>
<td>Design and Access Statement</td>
</tr>
<tr>
<td>73</td>
<td>- Mainly looks at the design options does detail amenity provision, residential tenures, employment uses for the site, pedestrian access, to buildings, design standards for Life Time Homes and Wheelchair Standards.</td>
</tr>
<tr>
<td>Strategic Development Committee Date and decision</td>
<td>Socio-Economic Assessment</td>
</tr>
<tr>
<td>4 August 09: 7 for and 1 against - granted with conditions</td>
<td>Council Planners requested a Socio-Economic Impact Assessment at the pre-application stage. The Report done by Barton Willmore (planning consultants) is fairly poor and done in a rapid context (26 pages, double spaced).</td>
</tr>
<tr>
<td>Ward</td>
<td>It mentions PPS1 (Creating Sustainable Communities, PPS3 (Housing), PPG13 (Transport), PPS6 (Planning for Town Centres). It also refers to South East Plan (to what extent this applies to Tower Hamlets is questionable), and the London Plan. It comments on the age profile, population, and refers to Tower Hamlets as a deprived borough. Analysis of health (note its does not investigate health profile) is as follows:</td>
</tr>
<tr>
<td>Bromley by Bow</td>
<td>&quot;Health Care - Doctors Surgeries: 5.21 Within approximately 2km of the Application Site there are 15 doctors surgeries. The NHS Choices website confirms that all of these practices are currently accepting new patients. Dental Practices: 5.22 Within approximately 2km of the Application Site there are ten dental practices. All of the dental practices are accepting new NHS patients&quot;</td>
</tr>
<tr>
<td>Site size</td>
<td>Effects on Health Care - Doctors Surgeries: 6.18 As previously stated the Proposed Development is likely to generate a new population of approximately 233 people. As some of the future occupiers of the Proposed Development are likely to be existing residents of LBTH, and therefore already registered with a doctor, and all doctor’s surgeries located within 2km of the Application site are able to accommodate new patients, the effect of this increased population will be negligible. NHS Dental Practices: 6.19 As all of the identified dental practices within 2km of the Application Site are taking on new patients; the Proposed Development will result in a negligible effect on dental practice provision. It should be noted that not all of the future occupiers of the Proposed Development will be seeking dental care as some will be relocating within the existing area and will already be registered with a dentist.&quot;</td>
</tr>
</tbody>
</table>

### Description of development

Demolition of existing 2190sqm (GIA) building currently used for clothing manufacture (Use Class B1c), and redevelopment to provide buildings of between five and nine storey’s for mixed-use purposes including 73 residential units (Class C3) (1 x studio; 20 x 1 bedroom; 36 x 2 bedroom; 16 x 3 bedroom), 1,300 sqm (GIA) of floor space for the manufacture of clothing (Use Class B1c) and 100 sqm (GIA) of flexible commercial floor space (Classes A1/A2/A3/A4/A5) or Gymnasium (Class D2), with associated roof terraces, landscaping, access and servicing.
### Consideration of Health

<table>
<thead>
<tr>
<th>Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Outlines studies done in relation to: design and access, landscape, community involvement, flood risk, site waste management, micro-climate, noise, sunlight/daylight, air quality, energy and transport.</td>
</tr>
<tr>
<td>Puts conditions on the following:</td>
</tr>
<tr>
<td>- employment initiatives for employing local people</td>
</tr>
<tr>
<td>- Green travel plan</td>
</tr>
<tr>
<td>- Sum of £10m for upgrading of the estate to Decent Homes standard</td>
</tr>
<tr>
<td>- Provision of a car club</td>
</tr>
<tr>
<td>- Provision and operation of a community centre</td>
</tr>
<tr>
<td>- 24hr public access to public open space</td>
</tr>
<tr>
<td>- construction working hrs</td>
</tr>
<tr>
<td>- construction noise levels</td>
</tr>
<tr>
<td>- Sustainable Homes assessment</td>
</tr>
<tr>
<td>- Land contamination</td>
</tr>
<tr>
<td>- Cycle storage</td>
</tr>
</tbody>
</table>

### Planning and Regeneration Statement

This is done by Leaside Regeneration on behalf of East End Homes. Focuses on Decent Homes standard and Housing Choice Programme in Tower Hamlets. Refers to the Tower Hamlets Community Strategy including the objectives of “A Great Place to Live” and “Healthy Communities”. It outlines the Statement of Community Involvement, why larger family units fall slightly below Council’s targets, Life Time Homes standard as well outline open space and play areas. It does not look at health directly nor analyse existing population or neighborhood context.

### Statement of Community Involvement

Points out that community has been carried out over the last 3.5 years. Consultation occurred with designers, crime prevention design officers, walking audits were also carried out. This contributed towards identifying residents view on what improvements needed to be made to existing stock and what should be considered as part of the development opportunity. Issues identified included loss of car parking space and problems with existing open space and plays areas. The health of residents was not considered.

### Design and Access Statement

Prepared by Jestico and Whiles, the statement looks at the nature of the existing blocks within the estate and proposed works including design and structural form. It proposes a number of design improvements such as new pedestrian connections and public open space have health implications but are not considered. As standard it devotes pages to Life Time Home standards refuse and amenity space considerations. Overall the document does not look at health or health implications.

### Note:

The regeneration project is part of the process to improve the estate and bring existing homes up to Decent Homes standard to ensure that they are in a good state of repair.

### Description of development

Refurbishment of the retained existing dwellings on Holland Estate, the replacement of 43 dwellings, (13 x one bed flats, 9 x two bed flats, 18 x three bed flats and 3 x four bed flats) totalling 143 habitable rooms within Ladbroke House, Bradbury House, Evershed House and Denning point with the erection of 209 new residential units containing studio, 1, 2, 3, 4 and 5 bedrooms, provision of a new community centre (use class D1) of 644sqm, a new East End Homes local housing office and head office of 1,078sqm (use class B1), the introduction of an Estate wide landscaping scheme and the replacement of 11 retail units (including 2 kiosks) with 6 new retail units providing some 1,490sqm comprising use classes A1, A2 and A3.

### Planning Application Number

PA/08/02347

### Location of Development

Holland Estate, Commercial Street, London

### Number of new housing units

209

### Strategic Development Committee Date and decision

13 May 09: 3 for and 0 against – granted subject to legal agreement, conditions and informative. Committee also recommended that applicant seek transitional support for retailers whose businesses will be affected by the development works.

### Ward

Spitalfields and Banglatown

### Site size

2.4 ha

### Environmental Impact Assessment (EIA)

Not stated within the Committee Report
### Consideration of Health

<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Committee Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/08/2292</td>
<td>- Outlines studies done in relation to: environment, design and access, energy, community involvement, affordable housing and economic appraisal, landscape.</td>
</tr>
</tbody>
</table>

Puts conditions on the following:
- To provide a minimum of 41.5% affordable housing across the sites
- Provision of further 56 units that contain a separate kitchen
- Sustainable Homes Standard minimum of 3, 4 were possible
- Hrs of construction
- Energy strategy
- Landscaping
- Details of acoustic glazing and ventilation
- Flood risk assessment

<table>
<thead>
<tr>
<th>Location of Development</th>
<th>Planning Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>443-451 Westferry Road, E14 (known as Island Point)</td>
<td>Not online</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of new housing units</th>
<th>Design and Access Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>189</td>
<td>Not available online due to size of the files</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Development Committee Date and decision</th>
<th>Statement of Community Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 April 09: 4 for and 2 against, granted subject to the legal agreement and conditions</td>
<td>Prepared by Quatro, involved a workshop, consultation newsletter, public exhibition and Community Forum participation. Issues identified for discussion did not identify health of the population but rather issues such as building shape, heights, materials, landscape, security and access, car and cycle parking, community space. There was a sentence on a new health centre being proposed, but local residents felt that the new GP surgery on Westferry Road provided enough capacity.</td>
</tr>
</tbody>
</table>

**Note:**
The application is linked to a proposal to redevelop the City Pride Public House, 15 Westferry (Ref. PA/08/2293)

---

**Description of development**

Erection of six buildings from 2 to 8 storeys in height to provide 189 residential units, with provision of basement and surface car parking, associated servicing and landscaping, together with incidental works. The application for planning permission is accompanied by an Environmental Impact Assessment pursuant to the Town And Country Planning (Environmental Impact Assessment) Regulations 1999.
<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/08/01321</td>
<td>Committee Report</td>
</tr>
</tbody>
</table>

**Location of Development**
Site at 2 Trafalgar Way

**Number of new housing units**
414

**Strategic Development Committee Date and decision**
2 April 09: 7 for and 0 against with 1 abstention subject to any directions from the Mayor and conditions.

**Ward**
Blackwall and Cubitt Town

**Site size**
0.4 ha

**Environmental Impact Assessment (EIA)**
Environmental Statement produced by Ramboll Whitby Bird. The non-technical summary paper looks at additional places for schools, health facilities, noise, vibration, air quality, land quality, micro-climate, daylight/sunlight, aviation, waste etc. It does not look at health issues.

**Description of development**
Redevelopment of the site (currently a McDonald drive through) to provide a residential-led mixed use scheme including two towers of 29 storey and 35 storeys and comprising 414 residential units, re-provision of drive through restaurant, retail / financial and professional service units, crèche, gymnasium, associated residential and community amenity space and car parking.

Note: Application was previously refused by Committee on level of residential development including family housing given site constraints. Family housing units now removed with financial contribution for off-site contribution.

<table>
<thead>
<tr>
<th>Committee Report</th>
</tr>
</thead>
</table>
- Outlines studies done in relation to: planning statement, community involvement, design and access statement, renewable energy, environmental and transport.
- Refers to no comments being received from LBTH Environmental Health on health but that they were satisfied that construction, noise/vibration, microclimate (wind) and BRE (daylight/sunlight) issues were mitigated through design while approaches to assess land contamination and air quality was appropriate.

**Puts conditions on the following:**
- Detail on children’s play area
- Parking for no more than 97 cars
- Hrs of construction/piling
- Details of ventilation system
- Renewable energy measures
- Land contamination
- Noise mitigation
- Air quality management
- Waste and recycling facilities
- Life Time Homes standard
- Code for Sustainable Homes compliance
- Details of CHAP
- Water supply impact

**Planning Statement**
Done by GVA Grimley. Refers to significant pre-application consultation, goes through site history and outlines planning benefits from red development. Nothing on health, but outlines how the development contributes a sustainable community via provision of quality playspace, skygardens, open space, balconies, public realm improvements, creation of a pedestrian-friendly environment, provision of accessible units accordance with disability access standards, re-provision of existing commercial operations which performs a local function etc.

**Refers to various PPS and PPGs, London Plan and Isle of Dog AAP. Outlines regeneration benefits, land use (retail, residential etc), housing mix, density, design, amenity space, biodiversity, public realm, transport, parking, servicing, refuse, archaeology, sustainability, flooding, noise, daylight/sunlight.**

**Statement of Community Involvement**
Done by Four Communications Ltd. Consultation mainly carried out via newsletters, exhibitions and meeting with Councilors. Details the process of consultation, dates, attendance etc. Key issues highlighted by residents included the need for high quality architecture, the issue of McDonalds remaining on site or not, density, design/materials used, pedestrian access and the effects of development on wildlife, traffic and parking were also identified as issues.

**Design and Access Statement**
Not available online
### Consideration of Health

**Committee Report**
- Outlines studies done in relation to: environmental impact assessment, design and access statement, energy, community involvement, affordable housing and economic appraisal.

Puts conditions on the following:
- Landscaping
- Acoustic glazing and ventilation
- Measures to mitigate wind impact
- Aircraft obstacle lighting
- Energy efficiency and passive design measures
- Details on CHP connections
- Renewable energy technologies

Reference is made to 3A.20 of the London Plan, 10D3 (health provision) of the Isle of Dogs AAP as well as a healthy community in terms of the Community Plan. Apart from consideration of health infrastructure there is no comment on health. The identified health club is for hotel use only.

**Sustainability Statement**
The locality analysis includes site analysis, built forms, views, transport, archeology, air quality, noise, vibration etc. Outlines what sustainable development means, various national and regional planning policy objectives, sustainable construction and adaption to climate change. In context of the latter there is mention of adequately sized rooms and spaces, inclusive design, community facilities, open space, cycling space and facilities, encouraging people to walk as part of the travel plan which have an impact on health but not acknowledged. The document also reviews air quality, pollution and flooding issues. It also comments on the need for the creation of mixed communities.

**Planning Statement**
Not online

**Statement of Community Involvement**
Done by Quatro Ltd. Involved workshop, consultation newsletter, website responses, public exhibition and Community Forum participation. The majority of newsletter responses did not support the proposals due to area already being overbuilt, loss of City Pride, building height, too many hotels and flats in the area, unaffordable homes for local people, loss of light, noise and dust issues. General issue of health was not considered.

**Design and Access Statement**
Not available online due to size

### Description of development
Erection of a 62-storey tower including basements, comprising 430 residential apartments (Class C3), amenity spaces and car parking; a nine storey podium building comprising a 203 bedroom hotel (Class C1), together with ancillary restaurants, conference facilities, health club and servicing and parking areas including drop-off facility; provision of a Class A3 and/or A4 use and/or amenity space at levels 60/61; provision of a unit for use either for Class A1 (Shop), A2 (Financial and professional services), A3 (Food and drink) and/or A4 (Drinking establishment) at ground floor; associated landscaping; together with incidental works.

<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/08/2293</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: environmental impact assessment, design and access statement, energy, community involvement, affordable housing and economic appraisal.</td>
</tr>
<tr>
<td>Location of Development</td>
<td></td>
</tr>
<tr>
<td>The City Pride Public House, 15 Westferry Road, E14</td>
<td></td>
</tr>
<tr>
<td>Number of new housing units</td>
<td></td>
</tr>
<tr>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Strategic Development Committee Date and decision</td>
<td></td>
</tr>
<tr>
<td>15 April 09: 5 for and 4 against – granted subject to legal agreement and conditions.</td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td></td>
</tr>
<tr>
<td>Millwall</td>
<td></td>
</tr>
<tr>
<td>Site size</td>
<td></td>
</tr>
<tr>
<td>0.2 ha</td>
<td></td>
</tr>
<tr>
<td>Environmental Impact Assessment (EIA)</td>
<td></td>
</tr>
<tr>
<td>Yes. Done by Waterman Environmental. There was no section on health. Did include issues on planning policy, socio-economics, archeology; transport and access, air quality, noise and vibration, ground conditions, water resources and flood risk, daylight/sunlight and over shadowing, wind, telecommunications, aviation, waste management and cumulative impacts</td>
<td></td>
</tr>
<tr>
<td>Description of development</td>
<td></td>
</tr>
<tr>
<td>Erection of a 62-storey tower including basements, comprising 430 residential apartments (Class C3), amenity spaces and car parking; a nine storey podium building comprising a 203 bedroom hotel (Class C1), together with ancillary restaurants, conference facilities, health club and servicing and parking areas including drop-off facility; provision of a Class A3 and/or A4 use and/or amenity space at levels 60/61; provision of a unit for use either for Class A1 (Shop), A2 (Financial and professional services), A3 (Food and drink) and/or A4 (Drinking establishment) at ground floor; associated landscaping; together with incidental works.</td>
<td></td>
</tr>
</tbody>
</table>
### 6. Planning Application Number

<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/08/02093</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: planning and regeneration statement, design and access, landscape, flood risk, arboricultural impact, air quality, ground conditions, transport assessment, archaeological assessment, energy strategy, report on daylight/sunlight and noise.</td>
</tr>
<tr>
<td></td>
<td>Puts conditions but none health related.</td>
</tr>
<tr>
<td><strong>Location of Development</strong></td>
<td>Planning and Regeneration Statement and Statement of Community Involvement.</td>
</tr>
<tr>
<td>The Bede Estate, Bow Common Lane, London</td>
<td>Done by Leaside Regeneration. Outlines the need for refurbishment and renewal of the estate due to it being run down. Outlines site and surrounding area, regeneration proposals including new community centre, retail units, refurbished stair cores, improving the quality, accessibility and provision of amenity space. Context relating to the need for Decent Homes Standards,</td>
</tr>
<tr>
<td><strong>Number of new housing units</strong></td>
<td>Refers to the Tower Hamlets Regeneration Strategy (2005) including the need to “improve the lives of local people in terms of safety, environment, health, prosperity, learning and achievement, leisure and public services.” It also outlines the third priority of the strategy which aims to develop places “which after a safe, healthy environment, mixed housing, wide-ranging services and facilities, pleasant open spaces and good transport links.”</td>
</tr>
<tr>
<td>236</td>
<td></td>
</tr>
<tr>
<td><strong>Strategic Development Committee Date and decision</strong></td>
<td></td>
</tr>
<tr>
<td>19 February 09: 5 for and 4 against – granted subject to legal agreement and conditions.</td>
<td></td>
</tr>
<tr>
<td><strong>Ward</strong></td>
<td></td>
</tr>
<tr>
<td>Bow West</td>
<td></td>
</tr>
<tr>
<td><strong>Site size</strong></td>
<td></td>
</tr>
<tr>
<td>5.3 ha</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental Impact Assessment (EIA)</strong></td>
<td></td>
</tr>
<tr>
<td>Not online</td>
<td></td>
</tr>
<tr>
<td><strong>Description of development</strong></td>
<td>In the statement of community involvement, it mentions that an extensive programme of consultation has been carried out with Bede residents over a 4 year period. The information gathered helped to identify residents views on what improvements should be made to the existing buildings and spaces as well as what developments opportunities should be considered. Issues identified included safety and security of the estate, poor state of repair including open space, lighting etc as well as need for new and improved facilities. No views on health were sought.</td>
</tr>
<tr>
<td>Refurbishment of the existing dwellings on the Bede Estate. Demolition of ten bed-sit units in Pickard House. Demolition of office accommodation on Wager Street. The erection of 24 buildings providing 236 residential units (22 x studio, 77 x 1 bed, 92 x 2 bed, 40 x 3 bed, 2 x 5 bed and 3 x 6 bed) to a maximum height of 8 storeys, a new community centre of 273sq.m and 219sq.m of new retail and storage floorspace and introduction of an estate wide landscaping scheme.</td>
<td></td>
</tr>
<tr>
<td>Note: The proposal will facilitate estate wide improvements and bring existing homes up to Decent Homes standards.</td>
<td></td>
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<tr>
<td>Planning Application Number</td>
<td>Consideration of Health</td>
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<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>PA/09/0203</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: design and access, heritage, daylight/sunlight, archaeological, trees, retail, air quality, transport assessment/green plan, landscape, planning statement, sustainability.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Location of Development</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Former Safeways, 2 Gladstone Place, London</td>
<td>Puts conditions on:</td>
</tr>
<tr>
<td></td>
<td>- Sound insulation mitigation,</td>
</tr>
<tr>
<td></td>
<td>- Lifetime Homes standards with 10% wheelchair access</td>
</tr>
<tr>
<td></td>
<td>- Secure by design</td>
</tr>
<tr>
<td></td>
<td>- Green travel plan</td>
</tr>
<tr>
<td></td>
<td>- Electrical charging points for vehicles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of new housing units</th>
<th>208</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Development Committee Date and decision</td>
<td>15 April 09: 6 for and 2 against – granted subject to legal agreement and conditions.</td>
</tr>
<tr>
<td>Ward</td>
<td>Bow East</td>
</tr>
<tr>
<td>Site size</td>
<td>0.75 ha</td>
</tr>
<tr>
<td>Environmental Impact Assessment (EIA)</td>
<td>Considered not necessary by Tower Hamlets for the scale and character of development proposed.</td>
</tr>
</tbody>
</table>

| Description of development | Demolition of the existing buildings occupying the site and its redevelopment to provide five buildings of between four and ten storeys in height accommodating 2,687sqm retail floorspace (Class A1) and 208 residential units (comprising 2 x studio, 81 x 1 bed; 76 x 2 bed; 39 x 3 bed; 4 x 4 bed; 6 x 5 bed), 104 parking spaces and landscaped public, communal and private amenity space. |

<p>| Planning Statement | Done by Nathaniel Lichfield and Partners. Reviews the site and surroundings, planning history, proposed development (goes through some of the same issues outlined in the Design and Access Statement), planning policy (PPS, London Plan, UDP, Tower Hamlets Central AAP, Interim Planning Statement on 2 Gladstone Place) and technical assessments. Reference is made to designing out crime, residential space and landscape requirements. Does not review health of local population nor consider health impacts of development. |</p>
<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/08/1763</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: sustainable strategy, Code for Sustainable Homes, transport statement and access, energy assessment, environmental statement, accessibility and Lifetime Homes, archaeological, design and access statement,</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Location of Development</td>
<td></td>
</tr>
<tr>
<td>Site at Caspian Works and Lewis House, Violet Road</td>
<td></td>
</tr>
<tr>
<td>Number of new housing units</td>
<td></td>
</tr>
<tr>
<td>191</td>
<td></td>
</tr>
<tr>
<td>Strategic Development Committee Date and decision</td>
<td></td>
</tr>
<tr>
<td>4 December 08: Unanimous vote subject to conditions</td>
<td></td>
</tr>
<tr>
<td>Ward</td>
<td></td>
</tr>
<tr>
<td>Bromley by Bow</td>
<td></td>
</tr>
<tr>
<td>Site size</td>
<td></td>
</tr>
<tr>
<td>0.85 ha</td>
<td></td>
</tr>
<tr>
<td>Environmental Impact Assessment (EIA)</td>
<td></td>
</tr>
<tr>
<td>Yes. Prepared by Barton Willmore. Non technical summary. Reviews socio-economics, transport and access, sunlight/daylight/overshadowing, microclimate, lighting, waste management; and telecommunications. Others aspects reviewed include ground conditions, geology, hydrogeology, flood risk, flora and fauna, air quality, noise and vibration, visual effects, ecology and archaeology. Socio-economic considerations was mainly related to infrastructure requirements schools, doctor's surgeries etc (here was no consideration of the health of the local population or potential residents). The main document does refer to deprivation but not much else.</td>
<td></td>
</tr>
<tr>
<td>Description of development</td>
<td></td>
</tr>
<tr>
<td>Redevelopment of site to provide buildings of between four (11.8 metres) and eleven storey's (32.2 metres) for mixed uses purposes including 191 (3 x studios; 54 x 1 bed; 91 x 2 bed; 36 x 3 bed; 7 x 4 bed) residential units Class A1, A2, A3 and B1 uses with associated basement and ground level car parking (70 spaces) and cycle parking (221), roof terraces, children's play area, landscaping, access and servicing.</td>
<td></td>
</tr>
</tbody>
</table>
9.

**Planning Application Number**
PA/08/1161

**Location of Development**
St Andrews Hospital, Devas Street, E3 3NT

**Number of new housing units**
964

**Strategic Development Committee Date and decision**
9 October 08: Unanimous vote subject to conditions

**Ward**
Bromley by Bow

**Site size**
3.01 ha

**Environmental Impact Assessment (EIA)**
Yes. Done by URS. It goes through options including no development and alternative sites. Reviews construction phases, planning policy context, sustainability criteria, traffic and transportation, construction and operational phases etc. In the socio-economic impacts it comments on leisure, recreation and open space standards, community services including health infrastructure. It reviews, housing and education profile of the borough, it only reviews healthcare facilities (GP surgeries) however and not health profile.

**Description of development**
Outline application for demolition of the existing hospital buildings and construction of a development up to 27 storey high building plus basement (Block D), 18 storeys high building (Block E) and between 4 – 13 storeys high buildings (Blocks A – C) to provide 964 dwellings (97 x studios, 300 x 1bed, 278 x 2 bed, 248 x 3 bed, 27 x 4bed, 14 x 5bed); up to 303sqm of shopping, food and drink or professional services floorspace (Use Classes A1, A2, A3 and A4), up to 897sqm of community, health, education and cultural uses floorspace (Use Class D1) and/or assembly and leisure uses (Class D2); and a 2004sqm Primary Care Trust (PCT) facility (Class D1), together with the provision of open space, landscaping, parking and ancillary works.

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**Consideration of Health**

**Committee Report**
- Outlines studies done in relation to: design and access, environmental statement, shadow analysis, transport assessment, travel plan, safety audit, statement of community involvement. The proposal outlines 5 development zones (blocks A, B, C, D and E). The proposal includes a healthcare facility (northern end of Block A) as well as provision of over 1 ha of open space. The development is considered to be in line with the Leaside AAP and Bromley-by-Bow masterplan, further the scheme provides 50.1% affordable housing and 30% family housing.

Puts conditions including: details of the fit-out of the healthcare facility, BREEM Healthcare assessment, final Code for Sustainable Homes assessment, Lifetime Homes standard and 10% wheelchair accessible homes

**Planning Statement**
Prepared by Cllr Richard Ellis. Refers to the masterplan (done by Allies and Morrison) for the site to help establish the development parameters (including as a low carbon scheme) and the nature of the application i.e. a hybrid. It then goes on to emphasize the strong engagement/community participation process between the local authority, key stakeholders and local community. It then goes on to outline site characteristics, proposal details, development plan and planning policy contexts. Full planning application sought for Phase 1a (a mixed-use scheme for 195 residential units and 2,084 sqm of non-residential floorspace including shopping, food, community, health (up to 2,390 sqm centre), education and cultural uses as well as ancillary facilities and services.

**Design and Access Statement**
Done by Allies and Morrison. Goes through location (i.e. Lower Lea Valley close to the 2012 Olympics site etc), connections (via site analysis), orientation, barriers, planning context (draft Bromley-by-Bow masterplan, LDF stage etc), local context, history (of the hospital site) and existing buildings, design options, public open place. Refers to a series of public consultation taken place during the development of the masterplan in the Bromley by Bow Centre. The statement refers lifetime Homes standard and 10% wheelchair accessible access, the health centre with pharmacy, community space, retail space provision of 1 ha of public open space for use by the wider community, extent to which the scheme is low carbon, level 3 Code for Sustainable Homes, minimal car parking, pedestrian, vehicular and street movement blocks, amenity space, massing, layout/mix, units and area schedule, phasing, approach of other architects involved in the scheme, tall buildings, typology, façade, materials, recycling, sustainability, vehicular access and parking. The only reference to health is in context of the proposed centre, wider links to health are not made.

**Statement of Community Involvement**
Prepared by HardHat Communications Ltd. The programme of community consultation a launch event, local stakeholder contact programme, website, public workshops, meetings, LAP meetings, news letters, workshops with local schools. Most of those consulted welcomed regeneration. Support was expressed for the need for having new homes and using the site to enhance the community, mixed tenure, shared equity, the incorporation of larger family housing was also welcomed. Some opposition to density levels, height of the tower located in the north-eastern part of the site and the impact of buildings on Devas Street. Others questioned the need for the community facility. Open space provision was welcomed by residents, the importance of making sure that public open space and parks were suitable for the elderly was highlighted. Concern was raised about street crime and the need for street lighting, surveillance, community policing, through-road or a rat run from Devas St to Devons Rd.
<table>
<thead>
<tr>
<th>Planning Application Number</th>
<th>Consideration of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA/07/2193</td>
<td>Committee Report</td>
</tr>
<tr>
<td></td>
<td>- Outlines studies done in relation to: design and access, sustainability, air quality, planning/socio economic, energy, geotechnical, transport assessment, sunlight/daylight, courtyard and design, heritage, tall buildings and townscape.</td>
</tr>
<tr>
<td>Location of Development</td>
<td></td>
</tr>
<tr>
<td>32-42 Bethnal Green Road, London, E1 6HZ</td>
<td></td>
</tr>
<tr>
<td>Number of new housing units</td>
<td></td>
</tr>
<tr>
<td>360</td>
<td></td>
</tr>
<tr>
<td>Strategic Development Committee Date and decision</td>
<td></td>
</tr>
<tr>
<td>13 March 08: 5 for and 4 against – granted subject to legal agreement and conditions</td>
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<tr>
<td>Ward</td>
<td></td>
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<tr>
<td>Weavers</td>
<td></td>
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<tr>
<td>Site size</td>
<td></td>
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<tr>
<td>0.6 ha</td>
<td></td>
</tr>
<tr>
<td>Environmental Impact Assessment (EIA)</td>
<td></td>
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<tr>
<td>The site is above the 0.5 ha threshold but screening by LBTH decided that an EIA was not required.</td>
<td></td>
</tr>
<tr>
<td>Description of development</td>
<td></td>
</tr>
<tr>
<td>Demolition of existing buildings and erection of 4 to 25 storey buildings to provide 3,443sqm of commercial floorspace within Use Classes A1, A2, A3,A4,B8,D1 and/or D2 together with 360 residential units, 83 car parking, bicycle parking, refuse/recycling facilities, access, public amenity space and new public square.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Planning/Socio-Economic Statement</td>
</tr>
<tr>
<td></td>
<td>Done by CMA Planning Ltd. List supporting documents including design and access, transport, environmental construction, renewable energy, sustainability, noise, air quality, heritage, townscape/visual assessment, sunlight/daylight, landscape strategy, community consultation, wind assessment, environmental/geotechnical, retail/commercial and tv reception. The document then goes to outline the site and surroundings (including nearby schemes), brief of the proposed development, development plan framework (London Plan, East London SRDF, Housing SPG, London View SPG, Industrial Capacity SPG, City Fringe OAPF, UDP/LDF). Planning appraisal looks at mix of uses, provision of new homes, commercial uses, the community facility, amenity space/playspace, regeneration issues, design and massing, sustainability and section 106 requirements. Outlines how the development can help better secure Rich Mix Centre opposite as well as consider the deprivation of the area and high levels of unemployment. No comment on health facilities or health profile of the local area.</td>
</tr>
<tr>
<td></td>
<td>Design and Access Statement</td>
</tr>
<tr>
<td></td>
<td>Looks at site location, broader site context, existing amenity provision, exiting uses, future/emerging development proposals, future transport infrastructure, constraints, opportunities, conceptual masterplan, location and design of tall buildings, conservation, public open space, wider regeneration issues, scheme proposal, housing tenure/dwelling mix, amenity, transport and parking, materials/specifications, access and inclusive design including location/facilities, design standards, wheelchair standard homes.</td>
</tr>
<tr>
<td></td>
<td>Public Consultation</td>
</tr>
<tr>
<td></td>
<td>Done by Lucis Communications Ltd. Consultation was mainly via public exhibition prior to the submission of the planning application. Nearly all of the visitors to the exhibition expressed the view that regeneration was a good opportunity to improve the locality and complement the Brick Lane area. They welcomed the proposed public square and the permeability offered from Bethnal Green Road/Cygnnet Street/Bacon Street. Most however had misgivings about the height of the tower element of the scheme especially in terms of daylight/sunlight issues</td>
</tr>
</tbody>
</table>